



fish creek

CHIROPRACTIC

Kids Health History (age 9-16)

Personal Information

Date: _____

Name: _____

How does your child wish to be addressed in our office? _____

Birth Date: _____ Male Female

Address: _____

City/Province/Postal Code _____

Guardian's E-mail Address: _____

Father's Name: _____ Father's Phone: _____

Mother's Name: _____ Mother's Phone: _____

Previous Chiropractor/ RMT: _____ Last Visit: _____

How did you hear about our office? _____

Current Health Profile

***If your child currently has no symptoms or complaints please skip to: General Health Profile.**

Health Concerns: List according to Their severity:	Severity: 1= mild 10= worst	When did this episode start?	If they've had this condition before, when?	Are symptoms constant or intermittent?
1. _____	____	_____	_____	_____
2. _____	____	_____	_____	_____
3. _____	____	_____	_____	_____
4. _____	____	_____	_____	_____

Please briefly describe your child's chief concern, including the effect it has had on their life:

Since the problem started, is it: About the same Getting Better Getting Worse

What makes it worse? _____

What has your child done that has helped them feel better? _____

What has your child done that was of NO help? _____

Other Health Care Professionals seen for this condition:

Name/Profession:	Date:	Diagnosis:	Treatment:	Results:
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____

Were x-rays taken? No Yes Area of body: _____ Date: _____

Current Medications & Supplements: _____

General Health Profile

Please indicate all symptoms your child has ever had, even if they do not seem related to their current problem. Use P for Past and C for Current.:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Urinary problem | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Loss of concentration | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Focus & memory issues | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Skin conditions | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Leg/foot pain | <input type="checkbox"/> Anxiety/stress | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Fever | <input type="checkbox"/> Tension |
| <input type="checkbox"/> TMJ pain/stiffness | <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Arm/hand pain | <input type="checkbox"/> Brain fog |
| <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Unexplained weight gain | <input type="checkbox"/> Joint pain |

Females Only: Date of last period: _____

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Cramps/backache | <input type="checkbox"/> Irregular menstruation | <input type="checkbox"/> Excessive flow |
| <input type="checkbox"/> Abnormal discharge | <input type="checkbox"/> Birth control pill | <input type="checkbox"/> Intra-uterine device | |

Stress Profile

Chronic physical, chemical and emotional stress is the cause of most health problems. Please review these common stresses and circle when your child experienced it in their life. Use P for Past and C for Current. Your answers will help us to determine what contributed to your child's present health.

Physical Stress:

Explanation:

- | | | | |
|---|---|---|-------|
| 1. Forceps, suction extraction, or caesarean delivery | P | C | _____ |
| 2. Accidents (auto, work related, falls or other) | P | C | _____ |
| 3. Surgical operations | P | C | _____ |
| 4. Strains, sprains, and/or broken bones | P | C | _____ |
| 5. Poor posture (excessive screen use, studying) | P | C | _____ |
| 6. Poor sleeping habits | P | C | _____ |
| 7. Sports injuries | P | C | _____ |
| 8. Overweight | P | C | _____ |
| 9. Lack of exercise | P | C | _____ |

Chemical Stress:

- | | | | |
|---|---|---|-------|
| 1. Take prescription or over-the-counter medication | P | C | _____ |
| 2. Use tobacco products | P | C | _____ |
| 3. Use artificial sweeteners (aspartame, sucralose) | P | C | _____ |
| 4. Poor diet (fast food, white flour, white sugar) | P | C | _____ |
| 5. Environmental pollution | P | C | _____ |
| 6. Energy drinks | P | C | _____ |
| 7. Recreational Drugs | P | C | _____ |

Emotional Stress:

- | | | | |
|--|---|---|-------|
| 1. Divorce of parents | P | C | _____ |
| 2. Death of a loved one | P | C | _____ |
| 3. Serious illness (self or a loved one) | P | C | _____ |
| 4. Procrastination | P | C | _____ |
| 5. Worry and/or fear | P | C | _____ |
| 6. Relationships | P | C | _____ |
| 7. Anger by you or at you | P | C | _____ |
| 8. Low self-esteem | P | C | _____ |

I authorize this office and its doctors to deliver care to my child as they deem necessary. I understand and agree that I am responsible for payment of all associated fees.

Guardian's Signature: _____

Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

PLEASE DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

Dated this _____ day of _____, 20_____.

Guardian Signature

Signature of Chiropractor

Guardian's Name (please print)