Children's Health History

To help us serve you better, please complete the following information.

Name: _____ Date:_____

Address: _____ City: _____Postal Code: _____

Date of Birth:_____ Phone:_____

Mother's / Guardian's Name_____ Work Ph: _____

Father's / Guardian's Name _____ Work Ph: _____

Who may we thank for referring you to our office? _____

Reason for contacting our office: _____

_____

Other professionals seen for this concern: _____

Please list treatments and results: _____

Other health concerns: _____

_____

Family health history: _____

Previous Chiropractor: _____Date of last visit: _____

Name of Pediatrician: _____

Date of last visit: _____Reason: _____

BIRTH HISTORY

Please check all that apply: ☐ Hospital ☐ Home Birth ☐ Birthing Center ☐ Midwife ☐ Forceps ☐ Vacuum Extraction ☐ C-Section ☐ Induced Labour

Other complications during birth? ☐ No ☐ Yes: _____

Medications given to mother during labour? ☐ No ☐ Yes: _____

Duration of birth: _____ hours APGAR at birth: _____ APGAR after 5 minutes: _____

Was the infant alert and responsive within 12 hours of delivery? ☐ Yes ☐ No

If no, explain: _____

GROWTH & DEVELOPMENT

Any signs that your child is not developing properly? ☐ No ☐ Yes: _____

Any growing pains? ☐ No ☐ Yes: _____

How many times has your child been sick in the last year? _____

Do sleeping patterns seem normal to you? ☐Yes ☐No: _____

CHEMICAL STRESSORS

Please rate on a scale of 1-10 (10 being the best) the mother's diet during pregnancy: _____
Mother smoked during pregnancy? □ No □ Yes Any smokers at home? □ No □ Yes
Drugs taken during pregnancy? □ No □ Yes If yes, which ones: _____
Ultrasounds during pregnancy? □ No □ Yes If yes, how many? _____
Any invasive procedures (amniocentesis, CVS)? □ No □ Yes: _____
Was this child breast fed? □ No □ Yes If Yes, for how long? _____
Was formula introduced? □ No □ Yes, at what age? _____
Was cow's milk introduced? □ No □ Yes, at what age? _____
Food intolerances? □ No □ Yes If yes, which foods? _____
Number of doses of antibiotics your child has taken: _____
Other prescription medication your child has taken: _____
Vaccination history: _____
Vaccine reactions (please circle): high pitched screaming, non-stop crying, fever, rashes hives, convulsions, seizures, other: _____
Any digestive problems? □ No □ Yes: _____
Any skin problems: □ No □ Yes: _____

EMOTIONAL STRESSORS

Please rate on a scale of 1-10 (10 being the most) the mother's stress during pregnancy: _____
Was this child allowed to bond immediately after delivery? □ No □ Yes
Any behavioural problems? □ No □ Yes: _____
Any □ night terrors, □ sleep walking, or □ difficulty sleeping?
Average number of hours of television/computer/ipad/ipod/video games per week? _____

PHYSICAL STRESSORS

Any traumas during pregnancy? □ No □ Yes
Any evidence of birth trauma: □ bruises □ odd shaped head □s tuck in birth canal
□ excessively long birth □ respiratory problems □ cord around neck □ other: _____
Any falls from couches, beds, change tables? □ No □ Yes: _____
Any traumas with bruising, cuts, stitches, fractures? □ No □ Yes: _____
Any hospitalizations? □ No □ Yes: _____
Any surgeries or organs removed? □ No □ Yes: _____
Sports played and age began? _____
Weight of school backpack? _____

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: _____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.
Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.
The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.
  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.
  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.
  Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.
  Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.
  The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

Date: _____ 20 _____ Date: _____ 20_____

_____ _____

Name (please Print) Signature of Chiropractor

_____

Signature of Patient (or legal guardian)