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)