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? _____

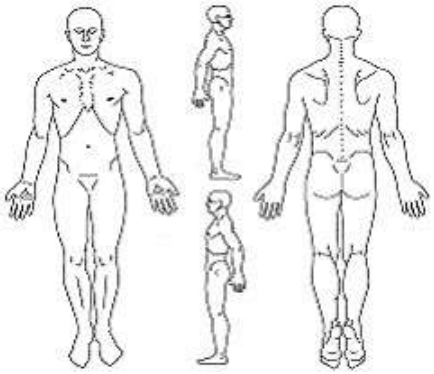
Current Health Profile

***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._____	___	_____	_____	_____

Using the appropriate letter from the legend below, please mark any and all areas where you feel pain, numbness, spasm, tenderness or any other sensation that is unusual or abnormal:

Aching – AA
Burning – BB
Cramps – CC
Dull – DD
Muscle Spasm – MM
Numbness – NN
Pins & Needles – PN
Sharp - SP
Shooting - SH
Stabbing – SB
Stiffness – ST
Swelling - SW
Throbbing - TT



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.:

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

Females Only: Date of last period: _____

Menstrual Pain	Cramps/backache	Irregular menstruation	Excessive flow
Abnormal discharge	Birth control pill	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: _____

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)