CHILD HISTORY

Please complete the following as completely as possible. Ask the front desk staff for assistance if needed.

Child's Name: _____ Date: _____

Child's Date of Birth: _____Age:_____ ❑ M ❑ F Referred by: _____

Parent(s) Name: _____Home # (__)_____Work# (__)_____

Address: _____City_____Prov. _____Postal code_____

Sibling(s) Name(s) (Ages):_____

Has your child ever been to a chiropractor? ❑ Yes ❑ No Who?_____Last visit date_____

Name of Medical Doctor: _____

Date of last MD visit and reason: _____

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

PARENT(S) NAME(S):_____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

PARENT/GUARDIAN SIGNATURE: _____Date _____

WITNESS SIGNATURE:_____

Present Health Complaints/Concerns

Major: _____

Minor: _____

When did this problem begin? _____

Is this problem: ❑ Occasional ❑ Frequent ❑ Constant ❑ Intermittent

Does problem radiate? ❑ Yes ❑ No If yes, where? _____

What makes this worse?_____

What makes this better?_____

Is the problem worse during a certain time of the day? ❑Yes ❑ No *If yes, when?* _____

Does this interfere with the child's ❑ Sleep? ❑ Eating? ❑ Daily Routine?

Is this becoming worse? _____

Other professionals seen for this condition? _____

Results with that treatment? _____

Name: _____ Date: _____

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS:

(please check if your child has had any of the following)

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Irritability
- ❑ Depression
- ❑ Loss Of Balance
- ❑ Loss Of Concentration
- ❑ Loss Of Memory
- ❑ Ears Buzzing
- ❑ Vision Changes
- ❑ Loss Of Smell
- ❑ Other:
- ❑ Loss Of Taste
- ❑ Light Sensitivity
- ❑ Cold Sweats
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Difficulty Breathing
- ❑ Shortness Of Breath
- ❑ Asthma
- ❑ Urinary Problems
- ❑ Diarrhea
- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Dental Problems
- ❑ Heart Palpitations
- ❑ Chest Pressure
- ❑ Breast Pain
- ❑ Frequent Colds
- ❑ Sinus Congestion
- ❑ Sore Throats
- ❑ Ear Pain / Infection
- ❑ Heartburn
- ❑ Bloating / Gas
- ❑ Upper Back Pain
- ❑ Neck Pain
- ❑ Radiating Pain
- ❑ Stiffness
- ❑ Reduced Mobility
- ❑ Numbness In Leg(s)
- ❑ Numbness In Feet
- ❑ Numbness In Hand(s)
- ❑ Muscle Cramps
- ❑ Sleeping Problems

History of Birth

What was the child's gestational age at birth? _____weeks.
Birth weight_____ lbs._____ oz. Birth length_____ inches
Was your child's birth ❑ at home ❑ in a birthing center ❑ in a hospital
Was the birth considered ❑ medical ❑ midwife
What was the duration of the labour and birth?_____hours
Was child born ❑ Cephalic (head first) ❑ Breech (feet first)
Were there any complications? ❑ Yes ❑ No *If yes, please explain:* _____

Check assistance used during the birth: ❑ Forceps ❑ Vacuum Extraction ❑ C-Section ❑ Episiotomy
Was labour: ❑ Spontaneous ❑ Induced
Were medications or epidurals given to the mother during birth? ❑ Yes ❑ No *If yes, what was given?* _____

APGAR score: at Birth _____/10 After 5 minutes _____ /10

Growth and Development

Was the infant alert and responsive within 12 hours of delivery? ❑ Yes ❑ No If no, please explain

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At what **age** did the child: Respond to sound_____Follow an object_____ Hold up head_____Vocalize_____
Sit alone_____Teeth_____Crawl_____ Walk_____

Do you consider the child's sleeping pattern normal? ❑Yes ❑ No If no, please explain_____

Name: _____ Date: _____

Family Health History

Note any health problems (eg. cancer, hereditary conditions, diabetes, heart disease,etc.) present in:
Mother's family _____
Father's family _____
Sibling(s) _____

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Physical Stressors

Any traumas to the mother during pregnancy? (eg. falls, accidents, etc.) ❑ Yes ❑ No *If yes, please explain:*_____

Any evidence of birth trauma to the infant? ❑ Fast Or Excessively Long Birth ❑ Bruising
❑ Odd Shaped Head ❑ Stuck In Birth Canal ❑ Cord Around Neck ❑ Respiratory Depression

Any falls from couches, beds, change tables, etc? ❑ Yes ❑ No *If yes, please explain:*_____
_____

Any traumas resulting in bruises, cuts, stitches, or fractures? ❑ Yes ❑ No *If yes, please explain:*
_____

Any hospitalizations or surgeries? ❑ Yes ❑ No *If yes, please explain*: _____
_____

Any sports played? _____
Is a school backpack used? ❑ Yes ❑ No *If yes, is it:* ❑ Heavy ❑ Light

Chemical Stressors

Was this child breast-fed? ❑ Yes ❑ No *If yes, how long?* _____

At what **age** were these introduced: Formula_____ What formula? _____
Cow's milk _____ Solid Foods_____ Type of foods?_____

Food / Juice intolerance? ❑Yes ❑No *If yes, what type?* _____

During pregnancy, did the mother: smoke? ❑ Yes ❑ No *If yes, how much?*_____
drink? ❑ Yes ❑ No *If yes, how much?*_____
Any illnesses during the pregnancy? ❑ Yes ❑ No *If yes, what illnesses?*_____
_____

Any supplements taken during pregnancy? ❑ Yes ❑ No *If yes, what supplements?* _____
_____

Name: _____ Date: _____
(day/month/year)

Any drugs taken during pregnancy? ❑ Yes ❑ No *If yes, what drugs?* _____

_____

Any ultrasounds? ❑ Yes ❑ No How many and reasons for being done? _____

_____

Any invasive procedures during pregnancy (eg. amniocentesis, CVS, etc.)? ❑ Yes ❑ No

*Please explain:*_____

Any pets at home? ❑Yes ❑ No *If yes, what kind(s)?* _____

Any smokers in the home? ❑Yes ❑ No

Vaccination History

Vaccinations given and age? _____

Any negative reactions? ❑Yes ❑ No *If yes, what were they?* _____

_____

Any antibiotics given? ❑Yes ❑ No *Reason?* _____

_____

Psychosocial Stressors

Any difficulties with lactation? ❑Yes ❑ No *If yes, what are they?* _____

Any problems with bonding? ❑Yes ❑ No *If yes, what are they?* _____

Any behavioural problems? ❑Yes ❑No *If yes, what are they?* _____

Any? ❑ night terrors ❑sleep walking ❑difficulty sleeping

Age of child when he/she began daycare? _____

Average number of hours of television per week? _____

Do you feel that your child's social and emotional development is normal for their age? ❑ Yes ❑ No
If yes, how? _____

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them here :

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by our 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 confirm the reason for chiropractic care is NOT related to an active motor accident vehicle claim or an active workman's safety and insurance board claim or an active personal injury claim. I understand reports will not be sent to lawyers as the office is not licensed to handle those types of cases.**

☐ **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.**

_____
Name (Please Print)

_____ _____
Signature of patient (or legal guardian) Date

_____ _____
Signature of Chiropractor Date

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