Practice Address:**11157 Ellerslie Rd SW**

Pediatric Case History

***Required** *All information contained in this questionnaire is strictly confidential.*

***Name:**	***Date of Birth**(dd/mm/yyyy)**:**	***Gender:** M☐ F☐
***Address:**	**Postal Code:**	
***Name/s of Parent/Guardians:**	***AHC #**	
***Phone:** (Cell)	(W)	(H)
Email Address:		
By providing your email address you consent to receive email communication from Jackson Chiropractic including appointment reminders, posture screening results, birthday emails and newsletters, you can unsubscribe from these emails at any time.		
Siblings Names & Ages:		
Are you a member of a health fund that pays for Chiropractic Care? ☐ Yes ☐ No ☐ Don't Know		
If Yes, please provide name of health fund:		
Who or what referred you to this Centre?		
Has your child ever had Chiropractic Care before? ☐ Yes ☐ No		
If Yes / Name of Chiropractor:		Located Where?
When was your child's last visit?	Reason for Care?	
What were the results of the treatment? **Please** ✓		
☐ Excellent / ☐ Satisfactory / ☐ Fair / ☐ Did not help / ☐ Got worse		
Did the Chiropractor take X-Rays? ☐ Yes ☐ No	Was your child examined thoroughly? ☐ Yes ☐ No	
Is there a family history of Scoliosis or other Spinal problems? If so, please describe:		
***Emergency Contact** (Name)	(Tel)	(Relationship)

Previous and Current Health

Name of Paediatrician:	Located where?
Date of last visit:	Reason for last visit:
Reason for your child's visit:	
Has your child had any other serious health problems within the past 3 years? ☐ Yes ☐ No	
If Yes, please describe what and when:	
Has your child ever been in a motor vehicle accident, had any sporting injuries or major falls? ☐ Yes ☐ No	
Has your child ever been hospitalised or had any operations? ☐ Yes ☐ No	
If Yes, please describe what and when:	
List any broken bones, fractures, dislocations or sprain injuries your child has had and when:	

Vaccination and Medicinal History

Has your child been vaccinated? ☐ Yes ☐ No
How many doses of Antibiotics has your child taken: Past 6 months? Total in his/her lifetime?
How many doses of Prescription Medications has your child taken: Past 6 months? Total in his/her lifetime?
Please list medications:
Is your child currently taking any type of medication, drugs or vitamins? ☐ Yes ☐ No
If Yes, **Please** ✓ ☐ Antibiotics ☐ Pain Medication ☐ Muscle relaxants ☐ Anti-inflammatory ☐ Vitamins ☐ Anti-depressants
☐ Other:
For what condition/s is your child taking this medication?

Patient Name:_____ **Date:**_____

Prenatal History			
Name of Obstetrician/Midwife:			
Complications during pregnancy? ☐ Yes ☐ No			
Ultrasounds during pregnancy? ☐ Yes ☐ No How many:			
Medication during pregnancy? ☐ Yes ☐ No			
Cigarette/Alcohol use during pregnancy: ☐ Yes ☐ No Location of birth: ☐ Home ☐ Hospital ☐ Birth Centre			
Type of birth: ☐ Vaginal ☐ C-Section ☐ Planned induction ☐ Emergency ☐ Forceps ☐ Suction/Vacuum Extraction			
☐ Normal ☐ Breech ☐ Posterior ☐ At term ☐ Premature ☐ Overdue			
Any complications during surgery? ☐ Yes ☐ No		Any Genetic disorders or disabilities? ☐ Yes ☐ No	
Birth weight:	Birth length:	APGAR scores:	
Was your child's head misshapen at birth? ☐ Yes ☐ No			

Feeding History		
Breast fed: ☐ Yes ☐ No If Yes, for how long:		
Formula fed: ☐ Yes ☐ No If Yes, for	Introduced to: Solids ____months	Cow's milk ____months
Food/juice allergies or intolerances: ☐ Yes ☐ No	If Yes, please describe:	

Has your child ever had any of the following?				
☐ ADHD	☐ Chronic colds	☐ Eczema/Psoriasis	☐ Measles	☐ Recurring tonsillitis
☐ Allergies	☐ Colic/Reflux	☐ Falls head first from high places	☐ Mumps	☐ Scoliosis
☐ Appendicitis	☐ Constipation/Diarrhea	☐ Growing/Back pains	☐ Poor coordination	☐ Seizures/Epilepsy
☐ Asthma	☐ Developmental disorders	☐ Headaches	☐ Poor sleeping habits	☐ Social disorders
☐ Bed wetting	☐ Digestive problems	☐ Juvenile Diabetes	☐ Pneumonia	☐ Travel sickness
☐ Chicken Pox	☐ Ear infections	☐ Learning disorders	☐ Recurring fevers	☐ Whooping cough
Other:				

What are your child's habits							
Has your child been in any of the following high impact or contact sports?							
☐ Soccer ☐ Football ☐ Gymnastics ☐ Karate ☐ Hockey ☐ Basketball ☐ Softball ☐ Dance ☐ Other							
According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life.							
Was this the case for your child? ☐ Yes ☐ No							
Had falls from:	☐ Bed	☐ Down stairs	☐ Off swings	☐ Change table	☐ Out of trees	☐ Off bike	Total number of falls:
During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for the prevention and early detection of vertebral subluxation (spinal nerve interference).							

Developmental History			
At what age was your child able to:			
Respond to sound:	Respond to visual stimuli:	Hold head up:	Sit up alone:
Cross crawl:	Stand alone:	Walk alone:	
Posture is the window to the spine. Abnormal or bad posture contributes to spinal stress and may lead to vertebral subluxation. Vertebral subluxations can severely inhibit the ability of the Nervous System to function at its optimum.			
Does your child often slump or sit with rounded back and shoulders? ☐ Yes ☐ No			
Does your child wear his/her backpack on both shoulders? ☐ Yes ☐ No			
How many hours per day does you child spend in front of the: Television: Computer:			
What position does your child sleep in at night? ☐ Side ☐ Back ☐ Stomach ☐ All			

JACKSON
CHIROPRACTIC

CONSENT TO CHIROPRACTIC TREATMENT - FORM L

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 mayor 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____.
Name (Please Print)

_____ Date: _____ 20____.
Signature of patient (or legal guardian)

_____ Date: _____ 20____
Signature of Chiropractor