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			

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

JACKSON CHIROPRACTIC

Updated: September 2025

CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

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

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about 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. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____
Patient Name (print)

_____ _____ _____
Patient/Guardian Signature Date Chiropractor Signature