CLAYTON PARK CHIROPRACTIC CENTRE INC.
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Health History Forms – Infant / Child

Child's Name: _____ Date: _____

Parent(s) Name: _____

Sibling(s) Name(s) & Age(s): _____

Address: _____ City: _____

Postal Code: _____ Cell #: _____ Home #: _____

We offer text reminders for your appts. If interested, who is your cell phone provider? _____

Email address: _____

Date of Birth: _____ Age: _____ □ M □ F Referred by: _____
mm/dd/yyyy

Has your child ever received chiropractic care? □ Y □ N If yes, please list previous DC's name and last visit date? _____

Name and phone number of Medical Doctor: _____

Date of last MD visit & Reason: _____

Present Health Complaints/Concerns
Please complete as appropriate, if there are no complaints/concerns please go to Family Health History
Major Health Complaint:

_____
Minor Health Complaint:

_____
When did the problem begin?

_____
Is the problem: □ Occasional □ Constant □ Intermittent
Does the 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? _____

Family Health History

Please note any health problems (eg. Cancer, hereditary conditions, heart disease, etc.) that are 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?
□ Bruising □ Odd shaped head □ Stuck in birth canal
□ Cord around neck □ Fast or Excessively long birth □ Respiratory Depression

Any falls from sofa's, beds, change tables, etc? □ 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 packed: □ Heavy □ Light

Chemical Stressors

Was this child breast-fed? □ Yes □ No, If yes, how long?

_____

At what age was formula introduced? _____ What formula? _____
At what age was cow's milk introduced? _____
At what age was solid food introduced? _____ Type of foods? _____
Food/Juice Intolerance? □ Yes □ No, If yes, what type? _____
During pregnancy, did the mother? Smoke □ Yes □ No How much? _____
Drink □ Yes □ No How much? _____
Any illnesses during the pregnancy? □ Yes □ No, If yes, what illnesses? _____

_____

_____

Any supplements taken during pregnancy? □ Yes □ No, If yes, what supplements?

_____

Any drugs taken during pregnancy? □ Yes □ No, If yes, what drugs?

_____

Often Seemingly Unrelated Symptoms Can Manifest As Other Health Concerns

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

□ Headaches □ Loss of Taste □ Weight gain □ Upper back pain
□ Dizziness □ Light sensitivity □ Dental Problems □ Neck Pain
□ Fainting □ Face Flushed □ Fevers □ Low Back Pain
□ Fatigue □ Cold Sweats □ Heart Palpitations □ Radiating Pain
□ Irritability □ Bronchitis □ Chest Pressure □ Stiffness
□ Depression □ Pneumonia □ Breast Pain □ Reduced Mobility
□ Loss of Balance □ Difficulty Breathing □ Frequent Colds □ Numbness in leg(s)
□ Loss of Concentration □ Shortness of Breath □ Sinus Congestion □ Numbness in feet
□ Loss of memory □ Asthma □ Sore Throats □ Numbness in hand(s)
□ Ears Buzzing □ Urinary Problems □ Ear Pain/Infections □ Weakness
□ Poor Coordination □ Constipation □ Allergies □ Muscle cramps
□ Vision Changes □ Diarrhea □ Heartburn □ Sleeping Problems
□ Loss of Smell □ Weight Loss □ Bloating/ Gas
□ Other:

_____

_____

History of Birth

What was the child's gestational age at birth? _____ weeks

Birth weight: _____lbs _____oz length _____ (inches)

Was your child's birth: □ at home □ in a birthing centre □ in a hospital?

Was the birth considered: □ medical □ midwife?

What was the duration of the labour and delivery? _____ hours

Was the child born: □ Cephalic (head first) □ Breech (feet first)?

Were there any complications? □ Yes □ No, If yes, please explain:

_____

_____

Please check any assistance, which was 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 (if known)

Growth and Development

Was the infant alert and responsive within 12 hours of delivery? □ Yes □ No, If yes, please explain: _____

_____

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:

Any ultrasounds? □ Yes □ No, How many and reasons for being done?

Any invasive procedures during pregnancy? (eg. Amniocentesis, CVS, etc.) Please explain:

Any pets at home? □ Yes □ No, If yes, what kinds?

Any smokers in the home? □ Yes □ No

Vaccination History

Did your child receive vaccinations? □ Yes □ No, If yes, which ones?

Any negative reactions? □ Yes □ No, If yes, please explain:

Any antibiotics given? □ Yes □ No, How many courses and why?

Psychosocial Stressors

Any difficulties with lactation? □ Yes □ No, If yes, what are/were they?

Any problems with bonding? □ Yes □ No, If yes, what are/were they?

Any behavioural problems? □ Yes □ No, If yes, what are/were they?

Any: □ night terrors □ sleep walking □ difficulty sleeping
Age of child when she/he 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?

If there are any other questions or concerns, which you have, you may write them in the space provided:

OFFICE FEE SCHEDULE & FINANCIAL POLICY

(Chiropractic prices are *not* subject to tax)

CHIROPRACTIC SERVICES:

	Dr. Doug + Dr. Sasha
Consultation (10min)	*NO CHARGE*
Initial Chiro Exam	$100.00
Chiro Adjustment	$65.00
Chiro Re-Assessment	$75.00
Chiro Reactivation	$75.00
Missed Appointment Charge	**$45.00**

FINANCIAL POLICY AND CHIROPRACTIC ACTIVE LIFE PLANS

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange a Chiropractic Active Life Plan in advance. These plans are designated to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Report of Findings appointment.

REGISTERED MASSAGE THERAPY SERVICES:

½ HOUR SESSION (specific area)	$56.52 (plus tax) = $65.00
1 HOUR SESSION	$86.96 (plus tax) = $100.00
1 ½ HOUR SESSION	$134.78 (plus tax) = $155.00
2 HOUR SESSION	$173.91 (plus tax) = $200.00

If less than 24 hours notice is given to cancel Massage Therapy a FULL APPOINTMENT FEE will be charged

NO DIRECT BILLING – Our office does NOT direct bill to any insurance company therefore **PAYMENT IN FULL IS DUE** on date of service.

We accept exact cash, debit or credit cards (Visa & Mastercard only)

This office is **SCENT SENSITIVE.** Please refrain from wearing strong perfumes and aftershaves during your visit.

I, (printed name) _____ have read and I understand the above policies.

_____ _____

Patient signature (or guardian) **Date**