PEDIATRIC HISTORY FORM

DEAR PATIENT:
It is a pleasure to welcome your family. To help us serve you better, please complete the following information. We look forward to working with you to obtain optimal health for your family through natural Chiropractic care.

FILE: _____ DATE: _____ DR: _____

PERSONAL INFORMATION

Child's Name: _____
Name of Parent/Guardian: _____
Address: _____
City: _____ Province: _____
Postal Code: _____ H. Phone: _____
Child's Age: _____ Height: _____ Weight: _____
Sex: ❒ Male ❒ Female
Birthdate: D_____ M_____ Y_____
Family Physician: _____ Date of last visit: _____
Name of Pediatrician: _____ Date of last visit: _____
Who may we thank for referring you: _____
Has your child ever received Chiropractic Care: ❒ No ❒ Yes

Name of previous Doctor of Chiropractic Consulted: _____
Date of last visit: _____
Reason for the last visit: _____

Number of doses of antibiotics your child has taken:
During the last six months: _____
Total during lifetime: ❒ Never ❒ 1-5 ❒ 6-10 ❒ more

Recent tests done: (list date beside)
❒ Blood Work_____ ❒ Urine_____ ❒ X-rays _____
❒ Other_____

Please indicate the purpose for your child's visit:
❒ Crisis Management ❒ Early Detection of Problem ❒ Prevention
❒ Wellness ❒ Maximizing Growth and Development
❒ Other

Who will be financially responsible for this account:
❒ Mother ❒ Father ❒ Other Guardian (s)
How will your account be taken care of:
❒ Visa ❒ Cash ❒ Interact ❒ Cheque

CURRENT HEALTH CONDITION

Describe the reason for today's visit: ❒ Spinal Evaluation
❒ Specific Health Condition

Describe the specific health condition:_____
_____

When did this condition begin?_____
Was it ❒ Suddenly or ❒ Gradually
Has this condition occurred before: ❒ No ❒ Yes When?_____
Is this condition: ❒ Occasional ❒ Frequent ❒ Constant ❒ Intermittent
Does this condition radiate: ❒ No ❒ Yes
If yes where?_____
What makes it worse?_____
What makes it better?_____
Does this condition interfere with your child's: Sleep ❒ No ❒ Yes
Eating ❒ No ❒ Yes
Daily routine ❒ No ❒ Yes

Is this condition getting worse: ❒ No ❒ Yes
What other professionals have you consulted for this condition?_____
_____
Treatment received: _____

Results: ❒ Good ❒ Fair ❒ Poor

PRENATAL AND BIRTH HISTORY

Name of Obstetrician/Midwife:_____
What was the term of your pregnancy:_____weeks.
Complications during pregnancy? ❒ No ❒ Yes
List:_____
Any traumas (falls, accidents) during pregnancy? ❒ No ❒ Yes
List:_____
Complications during delivery? ❒ No ❒ Yes
List:_____
Ultrasounds during pregnancy? ❒ No ❒ Yes Number:_____
Medications during pregnancy (prescribed and non-prescribed)? ❒ No ❒ Yes
List:_____
Medications or Epidural given during birth? ❒ No ❒ Yes
List:_____
Location of Birth: ❒ Hospital ❒ Home
Child Birth: ❒ Cephalic (head first) ❒ Breech (feet first)
Birth Intervention: ❒ None ❒ Forceps ❒ Cesarean Section ❒ Vacuum extraction
Was Labour: ❒ Spontaneous ❒ Induced
Did the mother smoke during her pregnancy? ❒ No ❒ Yes
How much? _____
Did the mother use alcohol during her pregnancy? ❒ No ❒ Yes
How much?_____
Genetic disorder or disabilities: ❒ No ❒ Yes List:_____
Was Intensive Care required? ❒ No ❒ Yes
Any evidence of birth trauma to the infant? ❒ Bruising ❒ Odd shaped head
❒ Stuck in birth canal ❒ Respiratory depression ❒ Fast or excessively long birth
❒ Cord around the neck
Birth weight:_____ **Birth length:**_____
APGAR Score: at birth____/10 After 5 minutes____/10

FEEDING HISTORY

Breastfed: ❒ No ❒ Yes How long:_____
Formula fed: ❒ No ❒ Yes How long:_____
Introduced solids at:_____months, cow milk at_____months
Types of solid food:_____
Food/Juice intolerance/allergies: ❒ No ❒ Yes Type:_____
Milk intolerance: ❒ No ❒ Yes

DEVELOPMENTAL HISTORY

Has your child fallen from bed, change table, couch, stairs? ❒ No ❒ Yes
If yes explain_____
Is/Has your child been involved in: ❒ Gymnastics ❒ Football ❒ Soccer
❒ Swimming ❒ Baseball ❒ Hockey ❒ Martial Arts ❒ Acrobatic Dancing
❒ Other:_____
Has your child ever been involved in a car accident? ❒ No ❒ Yes
Describe:_____
Has your child ever been hospitalized? ❒ No ❒ Yes
Describe:_____
Has your child ever been seen on an emergency basis? ❒ No ❒ Yes
Describe:_____
Did your child ever have major surgery? ❒ No ❒ Yes
Describe:_____
Is your child using a back pack? ❒ No ❒ Yes Is it heavy ❒ Light ❒
FEMALES ONLY: Onset of Menstruation? ❒ No ❒ Yes AGE:_____

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that your child has now or has had in the past.

❒ Vision changes	❒ Headaches	❒ Frequent colds
❒ Allergies	❒ Asthma	❒ Sleeping problems
❒ Bed wetting	❒ Colic	❒ Irritability
❒ Skin problems	❒ Hyperactivity	❒ Urinary Problems
❒ Digestive problems	❒ Bloating/Gas	❒ Loss of concentration
❒ Ear pain/infections	❒ Frequent crying	❒ Sore throats
❒ Breathing problems	❒ Fainting	❒ Fatigue
❒ Seizure	❒ Bronchitis	❒ Poor coordination
❒ Constipation	❒ Pneumonia	❒ Loss of balance
❒ Diarrhea	❒ Neck pain	
❒ Upper back pain	❒Low back pain	

❒ Other_____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic examination, adjustment and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above name procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT:

_____

PRINT PATIENT'S NAMESIGNATURE OF PATIENT
(OR PARENT/GUARDIAN)

_____

DATE SIGNED

*WITNESS TO SIGNATURE ABOVE*_____

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