Optimum Family CHIROPRACTIC INC.

PERSONAL INFORMATION

Name: _____ Preferred Name: _____ Date: MM/DD/YYYY
Birthday: MM/DD/YYYY Age: _____ Gender: M ○ F ○

Address: _____

City _____ Prov. _____ Postal Code: _____
Home #: _____ Cell #: _____ Work #: _____

E-Mail Address: _____

Mother's name: _____ Father's name: _____

Sibling _____ Age: ___ Gender: M ○ F ○ Sibling _____ Age: ___ Gender: M ○ F ○

Who may we thank for referring you to our office?

- ☐ Family/ Friend (name) _____
- ☐ Facebook
- ☐ Website
- ☐ Workshop (which group) _____
- ☐ Health Practitioner _____
- ☐ Walk-in
- ☐ Print Advertisement
- ☐ Other _____

CHIROPRACTIC HISTORY

Has your child ever been to a chiropractor before? ○ No ○ Yes Date of last visit: _____

Has a family member previously seen a chiropractor? ○ No ○ Yes if yes, Parent ___ Sibling ___

Name of chiropractor: _____

Reason for seeing them: _____

Describe your experience? _____

How frequently did you go for adjustments? _____

What made you decide not to return to see them? _____

PREGNANCY HISTORY

Were any supplements taken during the pregnancy? ○ No ○ Yes _____

Medications taken during pregnancy (Presc. or over the counter) ○ No ○ Yes _____

During the pregnancy did the mother Smoke? ○ No ○ Yes How much? _____

Drink? ○ No ○ Yes How much? _____

Any ultrasounds or other radiation? ○ No ○ Yes

If so, how many and for what reasons? _____

Were there any invasive procedures during the pregnancy (amniocentesis, CVS etc.)? ○ No ○ Yes

Please explain _____

Trauma/ illness during pregnancy _____

Please describe any emotional stress the mother experienced during the pregnancy: _____

_____

For Office Use Only

CORE:	Hx:	G:
C:		
L:		

LABOUR AND BIRTH HISTORY

Position during labour: ☐ On back ☐ Side ☐ Sitting ☐ Standing

Was labour induced? ☐ No ☐ Yes Reason? _____

Did the mother have an episiotomy? ☐ No ☐ Yes

Was monitoring used? ☐ Internal ☐ External

Location of birth? ☐ Home ☐ Hospital ☐ Birthing center

Birth assistants? ☐ Midwife ☐ Doula ☐ Medical Doctor ☐ None

Was the mother administered any drugs? ☐ Epidural ☐ Morphine ☐ Other _____

Was there any intervention used during birth? ☐ No ☐ Yes ☐ Forceps ☐ Caesarean ☐ Vacuum extraction

How many hours did labour last? _____ Birth weight _____ Birth length _____

Was there any evidence of birth trauma to the infant? Check all that apply:

☐ Bruising ☐ Stuck in birth canal ☐ Respiratory depression

☐ Odd shaped head ☐ Fast or excessively long birth ☐ Cord around neck

Were there any other complications during birth or Congenital anomalies/ defects present? ☐ No ☐ Yes

Please explain: _____

MEDICAL HISTORY

Has your child been vaccinated? ☐ No ☐ Yes ☐ Partial ☐ Alternate Schedule ☐ Homeopathic

Did you notice any negative reactions? ☐ No ☐ Yes _____

History of antibiotics? ☐ No ☐ Yes Reason? _____

Which ones and how many rounds? _____

Has your child taken prescription medications ☐ No ☐ Yes Reason? _____

Which ones and how many times? _____

Has your child taken over-the-counter medications? ☐ No ☐ Yes Reason? _____

Which ones and how many times? _____

Has your child had any surgery? ☐ No ☐ Yes Reason? _____

GROWTH AND DEVELOPMENT

Was child breast fed? ☐ No ☐ Yes For how long? _____

Difficulties with lactation: ☐ No ☐ Yes _____

Was Formula introduced? ☐ No ☐ Yes Reason? _____

Was cow's milk introduced? ☐ No ☐ Yes At what age? _____

Have solid foods been introduced? ☐ No ☐ Yes At what age? _____ 1st foods _____

Food intolerance? _____

Quality of Sleep: ☐ Good ☐ Fair ☐ Poor Number of hours _____

Did your child favour turning their head to one side while sitting, sleeping or nursing? ☐ No ☐ Yes; ☐ Left or ☐ Right

At what age did your child start: Roll Over_____ Crawl_____ Walk_____

Describe any complications or delays with motor development: _____

Any complications or delays noticed with speech development: _____

Any falls from couches, beds, change tables, etc...? ☐ No ☐ Yes _____

HEALTH CONCERNS: Please check (√) all that he/she has experienced in the last 12 months:

☐ ADD/ADHD	☐ Colic	☐ Food Sensitivities	☐ Sensory Processing
☐ Allergies _____	☐ Constipation	☐ Fever	☐ Skin issues
☐ Anxiety	☐ Cramps	☐ Focus ☐ Memory Issues	☐ Sleep Difficulty
☐ Asthma	☐ Depression	☐ Headaches ☐ Migraines	☐ Speech Development
☐ Autism Spectrum	☐ Diabetes	☐ Heart Conditions	☐ Swollen Tonsils
☐ Back pain	☐ Diarrhea	☐ Hip Dysplasia	☐ Torticollis
☐ Balance ☐ Coordination	☐ Dizziness ☐ Vertigo	☐ Neck ☐ Shoulder Pain	☐ Urinary Tract Infection
☐ Bedwetting	☐ Ear Infections ☐ Aches	☐ Plagiocephaly/Odd head shape	☐ Vision ☐ Hearing Issues
☐ Behaviour Issues	☐ Epilepsy ☐ Seizure	☐ Pneumonia ☐ Bronchitis	☐ Walking Development
☐ Cancer	☐ Feeding Difficulty	☐ Respiratory Issues	☐ Other: _____

Fill out ALL detail below for the 3 most concerning conditions that you checked off on the last page:

#1:_____

On a scale of 1-10 (10 being severe), how significant is the problem? _____/ 10

When did it start? _____ How? _____

Is it? getting better ○ getting worse ○ staying the same ○

Describe the problem? _____

Are you taking medication for this condition? No ○ Yes ○ Please List:_____

#2:_____

On a scale of 1-10 (10 being severe), how significant is the problem? _____/ 10

When did it start? _____ How? _____

Is it? getting better ○ getting worse ○ staying the same ○

Describe the problem? _____

Are you taking medication for this condition? No ○ Yes ○ Please List:_____

#3:_____

On a scale of 1-10 (10 being severe), how significant is the problem? _____/ 10

When did it start? _____ How? _____

Is it? getting better ○ getting worse ○ staying the same ○

Describe the problem? _____

Are you taking medication for this condition? No ○ Yes ○ Please List:_____

Special Note Have you taken any medication within the last 24 hours? No ○ Yes ○

Please List: _____

What parts of life is this interfering with: School ☐ Sleep ☐ Play ☐ Hobbies ☐ Exercise ☐ Family ☐ Social ☐

Positive mental attitude ☐ Other_____

Which part of life is most important to get back to ASAP? _____

Beyond feeling better, what 3 reasons you want to be healthier?

1) _____

2) _____

3) _____

Informed Consent

Chiropractic care has been proven to be safe, both clinically and scientifically for children of all ages. The risk of injuries and complication is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Although Chiropractic is reported to be the safest health care system in the world, there are a few "side effects" associated with it and we feel that it is responsible to let you know:

a. Research shows that the most common unpleasant effect following chiropractic care is temporary muscle soreness associated with the adaptive changes after the adjustment. This however is only temporary and generally not severe soreness.

b. While extremely rare, there have been reports of ligament sprains and rib fractures.

☐ I have read and understand the above consent. If I have any questions or concerns, I will discuss them with my Chiropractor.

☐ I understand that research is an important aspect for all health care disciplines. For this reason, I consent to my information being used for research data purposes. (Your full name will not be used).

☐ I consent to the care recommended by my Chiropractor and extend this consent to include all other Chiropractors in this office.

Child's name:_____ Parent/ Guardian:_____

Signature: _____ Witness:_____ Date:_____

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