PEDIATRIC HISTORY FORM (Age 15 and under)

Name:_____ Date:_____

Address:_____ City:_____ Postal Code:_____

Date of Birth:_____ Gender: Male___ Female___ Weight:_____ Height_____

Names of Parent/Guardians:_____

Telephone:_____-_____-_____ Bus:_____-_____-_____ Cell:_____-_____-_____

E-mail Address:_____

Referred by:_____

CHILD'S CURRENT PROBLEM:_____

When did this condition begin?_____

Is it Better?_____ Worse?_____ Comes and goes?_____

Other doctors seen for this condition:_____

Is this condition interfering with any of the following?

Sleep_____ Daily routine_____ Sports/exercise_____

Other (please explain):_____

Any other health concerns?_____

Family history:_____

Previous chiropractor:_____

Date of last visit:_____ Reason:_____

Family doctor:_____

Date of last visit:_____ Reason:_____

Number of doses of prescription medications your child has taken:

During the past six months:_____ List:_____

Total during lifetime:_____ List:_____

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Prenatal History

Name of obstetrician/midwife:_____

Complications/illnesses during pregnancy?_____

Medications during pregnancy?_____

Location of birth: Home_____ Hospital_____ Other_____

Complications during delivery?_____

Medications during delivery?_____

Birth intervention: Forceps___ Vacuum extraction___ Caesarean Section(emergency or planned?)___

Birth weight:_____ Birth length:_____

Nutritional History

Breast fed: Yes___ No___ How long?_____

Formula fed: Yes___ No___ How long?_____

Solid food: Yes___ No___ At what age were they introduced?_____

Food allergies or sensitivities?_____

Developmental History

According to the National Safety Council, approximately 50% of children fall from a high place during their first year of life (e.g. a bed, change table, down stairs, etc.). Was this the case with your child?

Yes___ No___ List:_____

Is/has your child been involved in any high impact or contact type sports (e.g. soccer, football, gymnastics, baseball, martial arts, figure skating, etc.)?

Yes___ No___ List:_____

Has your child ever been involved in a car accident?

Yes___ No___ List:_____

Has your child ever been hospitalized, had surgery or been seen on an emergency basis?

Yes___ No___ List:_____

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Adolescent History

Our purpose is to improve your child's function and quality of life. Lifestyle stressors can accumulate and result in loss of function.

Has your child ever had a serious fall or jump (e.g. off a bike, down stairs, out of a tree, off playground equipment, etc.)?

Yes___ No___ List:_____

On a scale of Poor-Good-Excellent, please describe your child's:

Eating habits:_____ Exercise habits:_____ Sleep habits:_____

How does your child sleep? Side___ Back___ Stomach___

List any medication, vitamins or nutritional supplements:

_____

Childhood Illnesses

☐ Chicken Pox	Age_____	☐ Mumps	Age_____	☐ Rubella	Age_____
☐Whooping Cough	Age_____	☐ Rubeola	Age_____	☐ Other	Age_____

If other, please list:_____

Has your child ever suffered from?

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioural Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Asthma
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Walking Trouble
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Sleeping Problems
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Fall off swing
☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall from crib	☐ Fall down stairs
☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide	
☐ Fall from changing table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	
☐ Allergies to:			
☐ Other:			

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Authorization for care of a minor

I hereby authorize Dr. Straus to examine and administer care to my son/daughter as she deems necessary. I clearly understand and agree that I am responsible for payment of all fees and charges by this office.

Date:_____ Signature:_____

PATIENT PRIVACY CONSENT FORM

Privacy of your personal information is an important part of our office providing you with quality chiropractic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information.

In this office, Dr. Catherine Straus acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

In this consent form, we have outlined what our office is doing to ensure that:

- only necessary information is collected about you,
- we only share your information with your consent,
- storage, retention and destruction of your personal information complies with existing legislation and privacy protocols,
- our privacy protocols comply with privacy legislation, standards of our regulatory body, the Chiropractic College of Ontario and the law.

Do not hesitate to discuss our policies with Dr. Straus or any member of our staff. Please be assured that every staff member in our office is committed to ensuring that you receive the best quality Chiropractic Care.

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENT'S PERSONAL INFORMATION

We are committed to collecting, using and disclosing your information responsibly and do so for the following purposes:

- To assess your health concerns, provide health care and advise you of treatment options.
- To establish and maintain contact with you.
- To remind you of upcoming appointments.
- To allow us to efficiently follow-up for treatment.
- To complete claims for insurance purposes.
- To validate visit dates and receipts upon your insurance company's inquiry.
- To invoice for goods and services.
- To process credit card payments.
- To collect unpaid accounts and follow-up on billing as required.
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others.

PATIENT CONSENT

I have reviewed the above information that explains how the Family Chiropractic and Wellness clinic will use my personal information and the steps that the clinic is taking to protect my information.

I, _____, agree that Family Chiropractic and Wellness can collect, use and disclose personal information as set out in the privacy policies above.

Signature:_____ Date:_____

*Signature of Parent or Guardian if under 16years:_____