

## Pediatric Health History

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth (dd/mm/yy): \_\_\_\_\_ Age: \_\_\_\_\_

Gender:  Male  Female      Parents: \_\_\_\_\_      Number of Siblings: \_\_\_\_\_

Address: \_\_\_\_\_ City/Prov.: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ AHC# \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ Last Visit to MD: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Has your child ever received chiropractic care?  Yes  No

If yes: Dr. \_\_\_\_\_ Approx. Date of Last Visit: \_\_\_\_\_

### EVENTS

There are many events that occur throughout childhood – starting with childbirth, then learning how to walk and playing childhood sports. These events can cause accumulated stress and result in loss of health potential. A child's spine is like a growing tree – "As the twig is bent, so grows the tree." Most times the effects are gradual, not even felt until we become adults. Answering the following questions will give us an understanding of you child's overall health and allow us to better assess their body's innate ability to be healthy. Please Check  the following.

**Tell us about your pregnancy:**

Did you carry to full term (40 weeks)?       If not, how many weeks gestation? \_\_\_\_\_

Did you consume alcohol during your pregnancy?       Did you smoke? \_\_\_\_\_

Did you take any medication during your pregnancy?       Details? \_\_\_\_\_

Describe any complications and when they occurred? \_\_\_\_\_

**Tell us about your labour and delivery of this child:**

Did you use a midwife?       Obstetrician?       Home birth?       Hospital?

Did you have a C-Section?       Vaginal birth?

Where you induced?       Epidural?       Were forceps used?       Vacuum Extraction?

What was the baby's APGAR Score at 1 minute?      /10 &      at 5 minutes?      /10      OR      not sure

Was there initial respiratory delay?       Purple markings on face?       Mis-shaped skull?       Jaundice?

Describe any problems during labour and delivery? \_\_\_\_\_

**Tell us about your child:**

Did you breast feed?       How long? \_\_\_\_\_      Bottle feed?       Formula? \_\_\_\_\_

Number of hours your child sleeps per night? \_\_\_\_\_ Hrs      Quality of sleep?  good       fair       poor

Was your child vaccinated?       List any vaccine reactions: \_\_\_\_\_

Where you told that you had a choice in vaccinating your child?  YES       NO

List any current medications or supplements your child is taking:

List any previous medication(s), for what condition and the number of times it was prescribed:

List any emergency/hospital visits:

**As a baby/toddler (birth to 4 years), did any of the following occur? (Please check ✓)**

- |                                                       |                                                     |
|-------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Fall from change table/crib  | <input type="checkbox"/> Bed wetting                |
| <input type="checkbox"/> Tumble down stairs           | <input type="checkbox"/> Frequent fevers            |
| <input type="checkbox"/> Involved in a car accident   | <input type="checkbox"/> Frequent bouts of diarrhea |
| <input type="checkbox"/> Play in "Jolly Jumper"       | <input type="checkbox"/> Did not gain weight        |
| <input type="checkbox"/> Fall of playground equipment | <input type="checkbox"/> Sleeping problems          |
| <input type="checkbox"/> Constipation                 | <input type="checkbox"/> Frequent colds             |
| <input type="checkbox"/> Frequent ear infections      | <input type="checkbox"/> Colic                      |
| <input type="checkbox"/> Reaction to vaccination      | <input type="checkbox"/> Other _____                |

**As a young child (5-12 years), did any of the following occur? (Please check ✓)**

- |                                                              |                                               |
|--------------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Fall from tree/playground equipment | <input type="checkbox"/> Bed wetting          |
| <input type="checkbox"/> Fall of a bicycle                   | <input type="checkbox"/> Hyperactivity/Autism |
| <input type="checkbox"/> Sports accident                     | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Car accident                        | <input type="checkbox"/> Allergies            |
| <input type="checkbox"/> Stomach pains                       | <input type="checkbox"/> Leg/knee pains       |
| <input type="checkbox"/> Scoliosis                           | <input type="checkbox"/> Frequent colds       |
| <input type="checkbox"/> Learning difficulties               | <input type="checkbox"/> Other _____          |

**SYMPTOMS AND ILL HEALTH**

**As a child or adolescent, has your child experienced any of the following? (Please check ✓)**

- |                                           |                                            |                                                |
|-------------------------------------------|--------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Arm/wrist pains   | <input type="checkbox"/> Foot/ankle/knee pains |
| <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Neck/back pains   | <input type="checkbox"/> Tingling in arms/legs |
| <input type="checkbox"/> Ringing in ears  | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Shoulder pains        |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Allergies         | <input type="checkbox"/> Fatigue               |
| <input type="checkbox"/> Hyperactivity    | <input type="checkbox"/> Stomach problems  | <input type="checkbox"/> "Growing Pains"       |
| <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Other: _____      |                                                |

**Present reason for consulting our office:**

- Maximizing personal and / or family health potential?
- Correction and prevention of an existing problem? (Please fill out the information below.)

If your child has symptoms or a complaint, briefly describe the problem here:

How and when did this problem start?

The problem is:     Constant     Comes & Goes     Radiates/Travels (where?)

If he/she is experiencing pain, is it:     Sharp     Dull     Throbbing     Aching     Shooting     Nagging

What aggravates the condition/pain?

What relieves the condition/pain?

Please describe any past or current treatment(s) and results:

Is there anything else you would like us to know?

# INFORMED CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

## Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

## Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.  
Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.  
The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

**Alternatives**

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

**Questions or Concerns**

You are encouraged to ask questions at any time regarding 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.

**Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.**

**DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR**

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

\_\_\_\_\_ Date: \_\_\_\_\_ 20\_\_\_\_.  
Name (Please Print)

\_\_\_\_\_ Date: \_\_\_\_\_ 20\_\_\_\_.  
Signature of patient (or legal guardian)

\_\_\_\_\_ Date: \_\_\_\_\_ 20\_\_\_\_  
**Signature of Chiropractor**

**OFFICE FEE SCHEDULE AND FINANCIAL POLICY**

**New Patient Service**

Initial Exam	\$ 80
Initial Exam Child	\$ 40
New Patient Orientation	No Charge

**Services**

Regular Office Visit / Adjustment	\$ 55
Child Office Visit	\$ 35
Senior / Student	\$ 40
Decompression Therapy	\$ 80

**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 service is rendered unless you choose an Active Life Plan. Active Life Plans include Corrective Adjustment Plans and Wellness Adjustment Plans. These Active Life Plans are designed 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 Chiropractic Report.

If you are injured in an auto accident, and have coverage, we will discuss billing options with you.

I have read and I understand the above policies.

\_\_\_\_\_

Date

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Printed Name