Children's Health History Form

Align Family Chiropractic & Wellness Centre
1534 Lasalle Blvd, Sudbury, ON, P3A 1Z7 | (705) 222-4097

Our focus is on helping people function optimally so that they can be stronger, healthier, and better able to adapt to everyday life. The information that you provide gives us a better understanding of physical, chemical and emotional stresses that can gradually accumulate over time and produce health problems. Please complete this form as thoroughly as possible and Dr. Faught will review it with you.

Date: _____

CONTACT INFORMATION

Child's Name: _____
Date of Birth: _____ Sex: ☐ Male ☐ Female
Address: _____ City: _____
Postal Code: _____
Phone: _____

Mother's/Guardian's Name: _____
Work Phone: _____
Father's/Guardian's Name: _____
Work Phone: _____

Who may we thank for referring you to this office: _____

MEDICAL INFORMATION

Reason for contacting this office: _____
(*If there are no current concerns and this assessment is to ensure optimum health, please check this box:* ☐)

Other Health Care Practitioners seen for this condition:___No ___Yes
If yes, Practitioner Names and Professions: _____
Please list treatments and results: _____

Other health problems: _____

Previous Chiropractor if any: _____
Date of last visit: _____ Reason: _____

Name of Pediatrician: _____
Date of last visit: _____ Reason: _____

Number of doses of antibiotics your child has taken: _____
Vaccination history: _____

CHILDHOOD "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 on the central nervous system 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 children become adults. Answering the following questions will give us an understanding of your child's overall health and allow us to better assess what may have influenced how your child's body has been growing. Please fill in the following:

Tell us about your pregnancy:

Did you carry to full term (40 weeks)? ☐ Yes ☐ No; if not, to how many weeks gestation? _____

Did you consume any alcohol during your pregnancy? ____ Did you smoke? _____

Ultrasound during pregnancy? ___ Notable results: _____

Did you take any medications during your pregnancy? Details: _____

_____

Describe any complications and when they occurred: _____

_____

Tell us about your labour and delivery of this child:

Birth weight: _____ Birth Length: _____

Please check all that apply below:

☐Midwife ☐ Obstetrician ☐ Home birth ☐ Hospital ☐ Birthing center

Type of Birth: ☐ Vaginal birth ☐ C-section ☐ Prolonged delivery ☐ Breech

☐ I was induced ☐ I had an Epidural ☐ Forceps were used ☐ Vacuum extraction ☐ Cord was around neck

Please fill in the pertinent details:

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?___ Misshapen skull? ___ Jaundice? ___

Describe any complications during labour and delivery: _____

Tell us about your child:

Did you breastfeed? ___ For how long? _____ Bottle feed? _____ Formula? _____

Age at which solids were introduced: _____ Any food sensitivities, allergies or intolerances: _____

Number of hours your child sleeps per night? ___ Quality of sleep: good___ fair___ poor___

Please check all vaccine reactions that apply: ☐ high pitched screaming ☐ non-stop crying ☐ fever

☐ rashes ☐ hives ☐ convulsions ☐ seizures ☐ other _____

List any <u>current</u> medications or supplements your child is taking: _____

List any <u>previous</u> medications, 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?

☐ Fall from change table/crib
☐ Frequent fevers
☐ Play in "Jolly Jumper"
☐ Fall off playground equipment
☐ Frequent ear infections
☐ Other _____
☐ Bed wetting
☐ Involved in a car accident
☐ Did not gain weight
☐ Constipation
☐ Colic
☐ Tumble down stairs
☐ Frequent bouts of diarrhea
☐ Sleeping problems
☐ Frequent colds

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

☐ Fall from tree/playground equipment
☐ Fall off a bicycle
☐ Car accident
☐ Leg/knee pains
☐ Learning difficulties
☐ Bed wetting
☐ Hyperactivity/Autism
☐ Allergies
☐ Scoliosis
☐ Other _____
☐ Sports accident
☐ Asthma
☐ Stomach pains
☐ Frequent colds

Developmental History

During the following times, your child's spine is most vulnerable to stress and should be checked routinely by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).
At what month was your child able to:

_____ Cross Crawl
_____ Respond to sound
_____ Hold head up
_____Sit up
_____ Stand alone
_____ Walk alone

According to the National Safety Council, approximately 85% of children fall from a high place during the first year of life (*i.e: a bed, change table, down stairs, walking*).

Was this the case with your child?___No ___Yes
Please describe: _____

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 and goes ☐ Radiates/travels (*where?*) _____

If he/she is experiencing pain, it is: ☐ 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?_____

Your Child's Mental/Emotional Stresses

Any problems with bonding: ☐ No ☐ Yes ☐ Unknown

Any behavioural problems: ☐ No ☐ Yes ☐ Unknown

Any night terrors, sleep walking, difficulty sleeping:___No ___Yes ___Unknown

Average number of screen-time hours per day: _____ per week: _____week

Do you feel that your child's social development is appropriate for his/her age:
☐ No ☐ Yes ☐ Unsure

Please indicate any conditions your child may have had or currently has:

☐ Poor appetite	☐ Rubella	☐ Diarrhea	☐ Paralysis	☐ Fainting
☐ Tuberculosis	☐ Hypertension	☐ Sinus trouble	☐ Colds/flu	☐ Asthma
☐ Cough	☐ Mumps	☐ Bed wetting	☐ Hyperactivity	☐ Eczema
☐ Chicken pox	☐ Backaches	☐ Broken bones	☐ Headaches	☐ Allergies
☐ Neck problems	☐ Heart trouble	☐ Chronic earache	☐ Bronchitis	☐ Dizziness
☐ Joint problems	☐ Leg problems	☐ "Growing pains"	☐ Epilepsy/Seizure	
☐ Behavioural problems		☐ Rheumatic Fever		

I hereby authorize this office and its Doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Dated this _____day of_____, 20_____.

_____ _____

Patient Signature (Legal Guardian) **Witness of Signature**

Name:_____ **Name:_____**

(Please print) **(Please print)**

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques, such as spinal adjustments, are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients experience short-term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and occurrence of stroke. Rather, recent studies indicate that patients may be consulting medical and chiropractic doctors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumber spinal adjustment, although no scientific evidence has demonstrated that such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment.

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge that I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general (including spinal adjustment), the treatment options, and recommendations for my condition and the contents of the Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any special recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this _____day of_____, 20_____.

_____	_____
Patient Signature (Legal Guardian)	**Witness of Signature**
Name:_____	**Name:_____**
(Please print)	**(Please print)**