

## PEDIATRIC HISTORY FORM

Dear new patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

PATIENT NAME: \_\_\_\_\_ HEALTH CARD # \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

PROVINCE: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_ HOME # \_\_\_\_\_

BIRTHDATE: (M) \_\_\_\_\_ (D) \_\_\_\_\_ (Y) \_\_\_\_\_ WORK # \_\_\_\_\_

SEX: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_

NAMES OF PARENTS/GUARDIANS: \_\_\_\_\_

**PURPOSE FOR CONTACTING US?** SPINAL CHECK-UP: \_\_\_\_\_ OTHER: \_\_\_\_\_

OTHER DOCTORS SEEN FOR THIS CONDITION: \_\_\_\_ Y \_\_\_\_ N

DOCTORS' NAMES & PRIOR TREATMENTS: \_\_\_\_\_

OTHER HEALTH PROBLEMS: \_\_\_\_\_

PERTINENT FAMILY HISTORY: \_\_\_\_\_

HAS THIS CHILD BEEN UNDER PREVIOUS CHIROPRACTIC CARE: \_\_\_\_ Y \_\_\_\_ N

DATE OF LAST VISIT: \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME OF PEDIATRICIAN: \_\_\_\_\_

DATE OF LAST VISIT: \_\_\_\_/\_\_\_\_/\_\_\_\_ REASON: \_\_\_\_\_

ARE YOU SATISFIED WITH THE CARE YOUR CHILD HAS RECEIVED HERE? \_\_\_\_ Y \_\_\_\_ N

NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS RECEIVED HERE? \_\_\_\_ Y \_\_\_\_ N

DURING THE PAST 6 MONTHS: \_\_\_\_\_ TOTAL DURING HIS/HER LIFETIME: \_\_\_\_\_

NUMBER OF DOSES OF OTHER PRESCRIPTION MEDICATIONS YOUR CHILD HAS TAKEN: \_\_\_\_\_

DURING THE PAST 6 MONTHS: \_\_\_\_\_ TOTAL DURING HIS/HER LIFETIME: \_\_\_\_\_

HAVE YOU CHOSEN TO VACCINATE THIS CHILD? \_\_\_\_ Y \_\_\_\_ N

REACTIONS FOLLOWING VACCINATION (UP TO 30 DAYS POST VACCINE): \_\_\_\_\_

**PRENATAL HISTORY:**

NAME OF OBSTETRICIAN/MIDWIFE: \_\_\_\_\_

COMPLICATIONS DURING PREGNANCY: \_\_\_\_ Y \_\_\_\_ N, LIST: \_\_\_\_\_

ULTRASOUNDS DURING PREGNANCY: \_\_\_\_ Y \_\_\_\_ N, NUMBER: \_\_\_\_\_

COMPLICATIONS DURING DELIVERY: \_\_\_\_ Y \_\_\_\_ N, LIST: \_\_\_\_\_

MEDICATIONS DURING PREGNANCY/DELIVERY: \_\_\_\_ Y \_\_\_\_ N, LIST: \_\_\_\_\_

LOCATION OF BIRTH: \_\_\_\_\_ HOSPITAL \_\_\_\_\_ BIRTHING CENTRE \_\_\_\_\_ HOME

BIRTH INTERVENTION: \_\_\_\_\_ FORCEPS \_\_\_\_\_ VACUUM EXTRACTION

\_\_\_\_\_ CESAREAN SECTION, EMERGENCY OR PLANNED: \_\_\_\_\_

APGAR SCORES \_\_\_\_\_, \_\_\_\_\_ CIGARETTE/ALCOHOL USE DURING PREGNANCY: \_\_\_\_\_ Y \_\_\_\_\_ N

GENETIC DISORDERS OR DISABILITIES: \_\_\_\_\_ Y \_\_\_\_\_ N, LIST: \_\_\_\_\_

BIRTH WEIGHT: \_\_\_\_\_ BIRTH LENGTH: \_\_\_\_\_

**FEEDING HISTORY:**

BREAST FED: \_\_\_\_\_ Y \_\_\_\_\_ N, HOW LONG: \_\_\_\_\_

FORMULA FED: \_\_\_\_\_ Y \_\_\_\_\_ N, HOW LONG: \_\_\_\_\_, TYPE: \_\_\_\_\_

INTRODUCED: SOLIDS AT \_\_\_\_\_ MONTHS, COW'S MILK AT \_\_\_\_\_ MONTHS

FOOD/JUICE ALLERGIES OR INTOLERANCES: \_\_\_\_\_ Y \_\_\_\_\_ N, LIST: \_\_\_\_\_

**DEVELOPMENTAL HISTORY:**

ACCORDING TO THE NATIONAL SAFETY COUNCIL, APPROXIMATELY 50% OF CHILDREN FALL FROM A HIGH PLACE DURING THE FIRST YEAR OF LIFE (i.e. A BED, CHANGING TABLE, DOWN STAIRS, ETC.). WAS THIS THE CASE WITH YOUR CHILD: \_\_\_\_\_ Y \_\_\_\_\_ N

IS/HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT OR CONTACT TYPE SPORTS (i.e. SOCCER, FOOTBALL, GYMNASTICS, BASEBALL, CHEERLEADING, MARTIAL ARTS, ETC.): \_\_\_\_\_ Y \_\_\_\_\_ N

LIST: \_\_\_\_\_

HAS YOUR CHILD EVER BEEN INVOLVED IN A CAR ACCIDENT: \_\_\_\_\_ Y \_\_\_\_\_ N, LIST: \_\_\_\_\_

HAS YOUR CHILD EVER BEEN SEEN ON AN EMERGENCY BASIS: \_\_\_\_\_ Y \_\_\_\_\_ N, LIST: \_\_\_\_\_

OTHER TRAUMAS NOT DESCRIBED ABOVE: \_\_\_\_\_ Y \_\_\_\_\_ N, LIST: \_\_\_\_\_

HOSPITALIZATION OR PRIORITY SURGERY: \_\_\_\_\_ Y \_\_\_\_\_ N, LIST: \_\_\_\_\_

**CHILDHOOD DISEASES:**

CHICKEN POX	Y / N AGE _____	MUMPS	Y / N AGE _____
RUBELLA	Y / N AGE _____	WHOOPIING COUGH	Y / N AGE _____
RUBEOLA	Y / N AGE _____	OTHER	Y / N AGE _____

DOES YOUR CHILD OR HIS/HER SIBLINGS SUFFER FROM:

ASTHMA	Y / N AGE _____	SKIN PROBLEMS	Y / N AGE _____
ALLERGIES	Y / N AGE _____	DIFFICULTY SLEEPING	Y / N AGE _____
HYPERACTIVITY	Y / N AGE _____	COLIC	Y / N AGE _____
BED WETTING	Y / N AGE _____	DIGESTIVE DIFFICULTIES	Y / N AGE _____
EAR INFECTIONS	Y / N AGE _____	(CONSTIPATION, DIARRHEA)	

**AUTHORIZATION FOR CARE OF MINOR:**

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTORS TO ADMINISTER CARE TO MY SON/DAUGHTER S THEY DEEM NECESSARY. I CLEARLY UNDERSTAND AND AGREE THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL FEES CHARGED BY THIS OFFICE.

**INFORMED CONSET TO CHIROPRACTIC ADJUSTMENTS AND CARE**

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Tests, with or without x-rays have been performed on you to minimize this risk to yourself. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions. If you have any questions about this, please ask your Chiropractor.

I have read the above statements and consent to treatment.

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_



## Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may 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 the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors 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 lumbar spinal adjustment, although no scientific evidence has demonstrated 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 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 this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any 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 (please print)

\_\_\_\_\_  
Name (please print)