HealthFirst CHIROPRACTIC & Wellness Centre

Pediatric Forms (0-7 Years)

Today's Date: _____

Information reviewed with parent/guardian:

Dr. Initials _____

Name of child: _____ Sex: M / F

Date of Birth: _____ Age: _____

Parent's Names: Mother _____

Father _____

Address: _____

City: _____ Postal Code: _____

Home Phone: (___) _____ Work Phone: (___) _____ Cell: (___) _____

Preferred number (circle one): Home / Work / Cell

Email: _____ ☐ I do not want to be contacted via email

Medical Doctor/Pediatrician: _____ Date of last visit: _____

MSP #: _____

Emergency Contact: _____ Phone: (___) _____ Relationship: _____

Has your child ever received Chiropractic care? Yes / No

If yes, who? _____ Approximately when? _____

How did you hear about our office? _____

Who may we thank for referring you? _____

What concerns do you have regarding the health of your child? When did it start? How did it start?

_____

_____

_____

LIFE EVENTS

PREGNANCY

How many weeks did you carry? _____

Did you require any medication or surgeries during this pregnancy? Yes / No

Did you have any complications through your pregnancy? Yes / No

_____

_____

BIRTH

The birth of your child can give vital clues as to potential spinal problems. Please answer the following questions about the delivery and birth of your child.

Home / Hospital Delivery		Midwife / Obstetrician	
Delivered Normally	Yes / No	Breech	Yes / No
Premature	Yes / No	Caesarian	Yes / No
At Term	Yes / No	Forceps	Yes / No
Late	Yes / No	Suction	Yes / No
Chemically Induced	Yes / No		

Other: _____

_____

Birth Weight: _____

How long were you in labour? _____ Hours

Do you believe the birth was traumatic for your child? Yes / No

Was your child's head misshapen at birth? Yes / No

Were there any delivery complications? Yes / No

Details: _____

_____

_____

BIRTH TO SIX MONTHS

Was your child breast fed? Yes / No For how long? _____

Was your child formula fed? Yes / No What type of formula? _____

Did your child suffer from colic? Yes / No If yes, how bad was it? Mild Moderate Severe

Did your child suffer from reflux? Yes / No If yes, how bad was it? Mild Moderate Severe

Would you say your child was a:

Very poor sleeper / Poor sleeper / Average sleeper / Good sleeper / Very good sleeper

OTHER PROBLEMS

Please indicate by circling any of the following conditions which your child has experienced in the past:

Headache	Allergies	Neck Pain
Back Pain	Constipation/Diarrhea	Earaches/Infections
Sinus Pain	Recurrent Tonsillitis	Bedwetting
Recurrent Chest Infections	Growing Pains	Hyperactivity
Loss of Appetite	Poor Sleeping Habits	Visual Disorders
Constant Fatigue	Arm/Leg Pains	Recurrent Stomach Aches
Scoliosis	Fever	Convulsions
Joint Pains	Asthma	Travel Sickness
Night Terrors	Seizures	Chronic Colds
Recurrent Fevers	Hip Problems	Digestive Disorders
Developmental Delay	Poor Social Skills	Messy Eater

Other: _____

_____

SCHOOL AGE CHILD:

Poor Co-ordination	Learning Difficulties	Poor Handwriting
Behavioural Issues	Diagnosed as ADD/ADHD	Delayed Verbally
Diagnosis of Autism	Difficulty Reading/Writing/Spelling	
Communication	Extreme Clumsiness	

Other: _____

_____

MEDICAL HISTORY

What age did your child begin crawling? _____

Is your child accident prone? Yes / No Any significant falls? Yes / No

Please describe any falls or accidents your child has had: _____

_____

_____

Has your child ever been involved in a motor vehicle accident? Yes / No

Has your child had any diseases/illnesses? Yes / No Details: _____

Has your child ever been hospitalized or had surgery? Yes / No Details: _____

_____

Has your child ever had any broken bones or sprain injuries? Yes / No Details: _____

_____

Is your child on medication? Yes / No If yes, explain: _____

How many doses of antibiotics has your child been on in the last six months? _____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

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.

_____

Name (Please Print)

_____ Date: _____ 20____

Signature of patient (or legal guardian)

_____ Date: _____20____

Signature of Chiropractor