taylor creek CHIROPRACTIC

Child History Form (0-5 years of age)

Please complete the following health questionnaire.

Child's Name: _____ Date: _____

Sibling(s) Name(s) (Ages): _____

Address: _____ City: _____Prov. _____

Postal Code: _____ Phone: _____ Child attends: ☐Daycare ☐School /grade _____

Date of Birth: _____ Age: _____ Gender: ☐ M ☐ F Referred by:_____

Birth Weight: _____ Birth Length: _____ Current Weight: _____

Has your child ever received chiropractic care? ☐Yes ☐No If yes, previous DC's name and last visit date?

_____

Name of Medical Doctor: _____

Date of last MD visit and reason:_____

AUTHORIZATION FOR CARE OF A MINOR

Parent/Guardian Name: _____Relationship: _____Cell:_____

Parent/Guardian Name: _____Relationship: _____Cell:_____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

PARENT/GUARDIAN SIGNATURE:_____ DATE: _____

Parent(s)/guardian(s) Email address: _____/_____

Present Health Complaints/Concerns:

Major: _____

Minor: _____

When did this problem begin?_____

Is this problem: ☐ Occasional ☐ Frequent ☐ Constant ☐ Intermittent

Does problem radiate? ☐ Yes ☐ No If yes, where?_____

What makes this worse? _____

What makes this better? _____

Is the problem worse during a certain time of the day? ☐ Yes ☐ No If yes, when? _____

Does this interfere with the child's ☐ Sleep? ☐ Eating? ☐ Daily Routine?

Is this becoming worse?_____

Other professionals seen for this condition? _____

Results with that treatment? _____

Drugs currently taking: ☐ Inhalers ☐ Antibiotics ☐ Ritalin (or equivalent) ☐ Tylenol/Ibuprofen ☐ Other:_____

Surgery: ☐ Tonsils/ adenoids ☐ Tubes in ears ☐ Hernia ☐ Appendix ☐ Other _____

Major falls/ trauma: ☐ concussion ☐ broken bone ☐ broke tooth ☐ stitches ☐ sprain/ strain

Have x-rays been taken in the last year? ☐ No ☐ Yes when & which area: _____

Has the child ever been in an automobile accident? _____

Has the child been to the Emergency Room? _____

Has the child ever been hospitalized? _____

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Below is a list of questions that may seem unrelated to the purpose of your appointment, however, please answer carefully as these problems can affect the overall course of chiropractic care.

PRENATAL HISTORY

Duration of gestation

☐ 40 weeks (9 months)
☐ Less than 40 weeks_____
☐ Falls/accidents during pregnancy

_____

_____

Labour/ Delivery

☐ Spontaneous Labour
☐ Induced Labour
☐ Vaginal
☐ C-Section
☐ Forceps
☐ Vacuum Extraction
☐ Breech
☐ Epidural
☐ Fast delivery
☐ Excessively long delivery

At birth did your child have

☐ Odd shaped head
☐ Bruising
☐ Respiratory distress
☐ Cord Around Neck

_____

Feeding history

☐ Breast fed_____months
☐ Bottle fed _____months
☐ Food sensitivities/allergies

_____

Hours of sleep_____/ night
The child sleeps his:
○ side ○ back ○ stomach

Sleeping concerns:

_____

INFANCY TO AGE 2

Has your child ever suffered from:

☐ Colic
☐ Reflux
☐ Recurrent ear infections
☐ Recurrent colds/flu
☐ Asthma/ Respiratory problems
☐ Walking problems
☐ Digestive/ Elimination problems
☐ Fall from high place (bed, stairs, table, sofa, other…

_____

AGE 2 TO PRESENT

Has your child ever suffered from:

☐ Neck pain
☐ Headaches
☐ Ear infections/ pain
☐ Recurrent colds/flu
☐ Recurrent fevers
☐ Sinus congestion
☐ Asthma/ Respiratory problems
☐ Bronchitis / pneumonia
☐ Mid back pain
☐ Constipation
☐ Diarrhea
☐ Stomach aches/ bloating
☐ Vomiting
☐ Hyperactivity
☐ Concentration issues
☐ Fatigue
☐ Fainting
☐ Bed wetting
☐ Vision changes
☐ Arm/ Hand pain
☐ Leg/ foot pain
☐ Walking problems
☐ Muscle cramps
☐ Coordination difficulty
☐ Learning difficulty

Does / did child ever participate in the following activities:

☐ Hockey
☐ Football
☐ Figure skating
☐ Dance
☐ Gymnastics
☐ Trampoline
☐ Horseback riding
☐ Soccer
☐ Rollerblading
☐ Snowboard/downhill skiing
☐ _____
☐ _____

DISEASES

☐ Measles
☐ Mumps
☐ Epilepsy/ seizures
☐ Whooping cough
☐ Asthma
☐ Pneumonia / RSV
☐ Croup
☐ Meningitis
☐ Chicken pox
☐ Eczema
☐ Allergies_____
☐ Other: _____

_____

TRAUMAS

☐ Concussion
☐ Broken bone_____
☐ Stitches_____
☐ Sprained joint
☐ Whiplash
☐ Fall from height
☐ Car accident
☐ Emergency care
☐ X-rays/ MRI/ CT scan

Information you believe is important that has not been asked: _____

Parent/ Guardian Signature: _____ Date: _____

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CHIROPRACTIC

Informed Consent to Chiropractic Care

Doctors of Chiropractic who use manual therapy techniques 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 may experience short term aggravation of symptoms, rib fractures, or muscles and ligament strains and sprains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence do 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 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 skin irritation/ bruising with the use of some types of instrument or therapy offered by some doctors of chiropractic.

e) Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that association with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.
I consent to the chiropractic treatments offered or recommended to me by my Chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care in this office. _____

Dated this_____day of _____, 20_____

_____ _____

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

_____ _____

Print Name **Print Name**