River North Family Chiropractic

Pediatric History Form

Patient Name_____ MBH#_____

Name of Parents / Guardians_____

Address _____City _____Province _____PC_____

Phone(H)_____ Phone(C)_____ Email _____

Birth Date _____ Sex_____ Weight_____ Height_____ Number of siblings_____

Who referred you to us? _____

Reason for seeking chiropractic care: _____

Other Doctors seen for this condition? Y/N Specialty:_____

Prior treatment and outcome: _____

Other Health Problems: _____

Symptoms: Please check any current or past problems your child has on the list below:

_ Dizziness
_ Backaches
_ Heart Condition
_Chronic Earaches
_ Diabetes
_Tuberculosis
_Hypertension
_ Fever/Chills
_Frequent Colds
_ Headaches
_ Asthma
_ Allergies

_ Itchy Eyes
_ Rashes
_ Unusual Moles
_ Neuritis
_ Digestive
_ Sinus Trouble
_ Cough/Wheeze
_ Chest Pain
_Constipation
_ Anemia
_Rheumatic Fever
_ Runny Nose

_ Diarrhea
_ Poor Appetite
_Hyperactivity
_ Behavioral
_ Poor Memory
_ Insomnia
_ Nightmares
_ Bed Wetting
_ Pain Urinating
_ Convulsions
_Paralysis
_ Muscle Pain
_ Fainting

_ Broken bones
_Sprains/Strains
_ Neck Pain
_ Arm/Elbow Pain
_ Leg/Hip Pain
_ Knee/Foot Pain
_ Growing pains
_ Joint Pain
_ Scoliosis
_ Blood disorders
_Stomach Aches
_Other

Health History:

Name of Doctor: _____ Date of last visit _____

Medications and conditions being treated: _____

Has your child ever taken antibiotics? Y/N Condition treated: _____

Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Y/N

If yes, describe (Sprain, Broken Bone, Head Trauma..) _____

Has your child ever been involved in a car accident? Y/N Date & Injuries _____

Has your child ever fallen head first from (Changing Table, Bed, Stairs..) Y/N When?_____

Other traumas not described above? Y/N Type & Date: _____

Has your child been vaccinated? Y/N Has your child ever experienced any adverse reactions? Y/N

Feeding History:

Breast Fed?: Y/N How long?:_____ Formula fed: Y/N How long'?_____

Introduced to solids at _____ months. Other Dairy at _____ months

Food / juice allergies or intolerances Y/N List: _____

Developmental History:

Sleep (Hrs per night) _____ Naps (number & lengths) _____ Problems sleeping _____
At what age was your child able to: Crawl ___ Sit alone ___ Stand alone ___ Walk alone ___ Say words ___

Childhood Diseases: (please circle)

Chicken Pox - Age ___ Mumps - Age ___ Rubella - Age ___ Whooping cough - Age ___
Measles - Age ___ Meningitis - Age ___ Tuberculosis - Age ___ Other - Age ___

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment FORM L

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:_____ **Name:_____**
(please print) **(please print)**