Balanced Health and Sports Therapy

Chiro ● Physio ● Massage

PEDIATRIC HISTORY FORM

Dear Patient: It is the duty of your doctor of chiropractic to be able to assess the health of your child. Answering the following questions enables your chiropractor to understand the challenges your child may have experienced and provide him or her with the best care possible. We look forward to enhancing the health of your family. Welcome to our clinic!

Patient's Name: _____ Date:_____
Alberta Health Care No: _____ Date of Birth (M/D/Y):_____
Mother's Name: _____ Father's Name:_____
Address: _____
City: _____ Postal Code:_____ Phone No: _____
Parent's Work No(s):_____
School Attending: _____
Pediatrician: _____

Current Complaint: _____
_____
How long has this been troubling your child? _____
Other treatments pursued for this condition: _____
Have you been satisfied with this previous treatment? _____

Birth History:
Did you have an obstetrician or a midwife? _____
Were there any complications with your pregnancy? If so, please explain:
_____
Did you have any ultrasounds? _____ If yes, how many? _____
Did you take any medications during pregnancy? _____
Cigarette or alcohol use during pregnancy? _____
How long were you in hard labour? _____
Did your child have:
A vaginal birth An assisted birth Vacuum (suction) Forceps C-section
APGAR score at birth: _____

Feeding History:
Was your child breastfed?_____ If yes, how long? _____
Formula?_____ Type?_____
At how many months was your child introduced to solids? _____
At how many months was your child introduced to cow's milk? _____
Please list food/juice allergies or intolerances:_____

Did your child experience any of the following? (Please circle)

Ear Infections	Colic	Hyperactivity	Whooping cough
Chicken Pox	Mumps	Allergies	Bowel Difficulties
Rubella	Rubeola	Asthma or other breathing difficulties	

Other: _____

1519 – 19th Street NW, Calgary, AB T2N 2K2
Phone: (403) 282-0880 Fax: (403) 282-0898

Did your child receive any vaccinations? ___If so, which ones? (Please circle)
DPT MMR OPV Rubella Haemophilus Influenza

Did your child react adversely to any vaccinations? (Please circle)

Fever	Skin Rash	Swollen Lymph Nodes
Nausea	Vomiting	High Pitch Cry
Paralysis	Convulsions	Allergies (anaphylactic shock)
Collapse	Deafness	Learning Disabilities

Does your child suffer from colds and the flu? (Please circle)
Regularly Sometimes Never

Has your child received medications in the past? _____
If so, what kind, and when? _____
How many courses of medication? _____
If so, is the medication working, or did it work? _____

National averages cite that approximately 70% of infants fall from a high place (such as a change table) before the age of one. Is this the case with your child? Please describe: _____
_____

Has your child been involved in high impact or contact sports? (Soccer, hockey, gymnastics, etc.) Please list: _____

Has your child experienced any other injuries? _____
Has your child ever been involved in a motor vehicle accident? _____
Has your child ever been hospitalized or brought to emergency? If so, please explain: _____

Has your child received chiropractic care in the past? _____
Chiropractor's Name: _____
Has your child received massage therapy? _____
RMT's Name: _____

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 rather, recent studies indicate 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)