



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 help 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: _____ Date: _____
Address: _____ City: _____
Province: _____ Postal Code: _____ Home # _____
Date of birth: (M) ____ / (D) ____ / (Y) ____ Work # _____
Sex: _____ Weight: _____ lbs Height: _____ Cell # _____
Names of Parents/Guardians: _____

Purpose for contacting us?

Spinal Check-Up: _____ Other: _____
Other doctors seen for this condition: YES NO
Doctors names & Prior treatments: _____

Other health problems: _____

Pertinent family history: _____

Has this child been under previous chiropractic care? YES NO Date of last visit: _____
Name of pediatrician: _____ Date of last visit: _____
Reason for visit: _____

Number of doses of antibiotics your child has taken during the past 6 months: _____
Total of antibiotics during his/her lifetime: _____
Have you chosen to vaccinate this child: YES NO
Reactions following vaccination (up to 30 days post vaccine): _____

Prenatal History:

Name of obstetrician/midwife: _____
Complications during pregnancy: YES NO List: _____

Ultrasounds during pregnancy: YES NO Number: _____
Complications during delivery: YES NO List: _____

Medications during pregnancy/delivery: YES NO List: _____
Location of birth: Hospital _____ Birthing centre _____ Home: _____
Birth intervention: Forceps: _____ Vacuum Extraction: _____ Cesarean section: _____
Emergency/Planned: _____
Apgar scores: _____, _____ Cigarette/Alcohol use during pregnancy: YES NO
Genetic disorders or disabilities: YES NO List: _____
Birth weight: _____ Birth Length: _____

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Feeding History

Breast Fed: YES NO How Long: _____
Formula Fed: YES NO How Long: _____ Type: _____
Introduced: Solids at _____ Months Cow's milk at _____
Food/Juice allergies or intolerances: YES NO 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. bed, changing table, down stairs, etc.), was this the case with your child: YES NO Explain: _____

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, hockey, gymnastics, baseball, cheerleading, martial arts, etc). YES NO List: _____

Has your child ever been involved in a car accident: YES NO List: _____

Has your child ever been seen on an emergency basis: YES NO List: _____

Other traumas not described above: YES NO List: _____

Hospitalization or priority surgery: YES NO List: _____

Childhood Diseases:

Chicken Pox Y/N Age: _____ Mumps Y/N Age: _____
Rubella Y/N Age: _____ Whooping 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 A MINOR

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

INFORMED CONSENT TO CHIROPRACTIC 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 treatments. 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.

Patient Name Patient Autograph Date