

YFCHIROPRACTIC

2991 Bathurst St.
Toronto, ON.
M6B 3B3

CHILD HEALTH HISTORY FORM (0-16 y/o)

Date: _____

Whom may we thank for referring you to our office? _____

Name _____ Date of Birth ____/____/____

(As it appears on birth certificate)

Address _____ City _____ Province _____ Postal Code _____

Phone (Home) _____ Mothers mobile: _____ Fathers mobile: _____

Mother _____ DOB ____/____/____ Father _____ DOB ____/____/____

Pediatrician/Family MD _____ City & Prov. _____ Last Visit: ____/____/____

Purpose of last visit _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ Age: _____

Ever been under chiropractic care? No Yes: Who/When? _____

Who is responsible for this bill? Mother Father Other (please explain) _____

PREGNANCY HISTORY:

Third Trimester Presentation: _____ Vertex _____ Breech _____ Transverse _____ Face/Brow

Type of Birth: _____ Normal Vaginal _____ Forceps _____ Cesarean _____ Suction Cap or Vacuum

Location: _____ Home _____ Hospital _____ Birthing Center _____ Other: _____

Problems during Pregnancy: _____

Problems during Labor/Delivery: _____

Was there presence of: _____ Jaundice? (Yellow) _____ Cyanosis? (Blue) _____ Congenital Anomalies/Defects?

If yes, please explain _____

INFANT HISTORY:

Infant feeding: _____ Breast _____ Bottle If Bottle; which formula? _____

Number of hours sleep per night _____ Quality of sleep: _____ Good _____ Fair _____ Poor

List all **IMMUNIZATIONS** you child has had: _____

Has your child ever been treated at the emergency room? _____ If yes; please explain _____

Has your child ever been hospitalized? _____ If yes; please explain _____

Has your child ever had any surgeries? _____ If yes; please explain _____

Is your child currently on any medication? _____ If yes; please list: _____

Office Use Only:

- Insurance
- Signed Credit Form
- Read Subluxation Pamphlet
- Family Checked
- Regular NP
- Whoelse NP
- MVA/WSIB NP

Other: _____

AT WHAT AGE DID THE CHILD?

Respond to sound _____ Follow an object with his/her eyes _____ Hold head up _____
Sit Alone _____ Crawl _____ Stand _____ Walk alone _____

AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING?

Chicken pox _____ Mumps _____ Measles _____ Rubella _____
Whooping Cough _____ Other: _____

HAS YOUR CHILD EVER SUFFERED FROM?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Ruptures/Hernia |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Reflux | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Backaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Allergies to _____ |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Allergies to _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies to _____ |
| <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Walking Trouble | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Other: _____ |

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS?

- | | | |
|---|---|--|
| <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall off skateboard or skates |
| <input type="checkbox"/> Fall from crib | <input type="checkbox"/> Fall off swing | <input type="checkbox"/> Fall off bicycle |
| <input type="checkbox"/> Fall from high chair | <input type="checkbox"/> Fall off slide | <input type="checkbox"/> Fall down stairs |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Other: _____ |

Has your child ever sustained an injury playing organized sports? _____ If yes; please explain _____

Has your child ever sustained an injury in an auto accident? _____ if yes; please explain _____

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: Write "C" for child, "F" for family member:

- | | | |
|-------------------------------|--------------------------------|----------------------|
| ____ Heart Disease | ____ Diabetes | ____ Stroke |
| ____ Cancer | ____ High / Low blood pressure | ____ Asthma |
| ____ Gastrointestinal disease | ____ Memory/mood disorder | ____ Thyroid problem |

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____ Wellness _____ Check-up _____ Other: _____
_____ Pain/Discomfort; explain _____
_____ Injury; explain _____

If due to Pain/Discomfort/Injury, please fill out:

- Onset of Problem: Date ____/____/____ _____ Unknown _____ Gradual _____ Sudden
- Ever had this problem before? No Yes If yes when? _____
- Any bowel or bladder problems since this problem began?: No Yes (Describe): _____
- Any medication taken for this problem? No Yes: _____
- Have you seen any other doctors for this problem? No Yes: _____
- How is this problem NOW: Rapidly Improving Improving Slowly About the Same Gradually Worsening On & Off

CONSENT TO CHIROPRACTIC

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

When a patient seeks chiropractic care in this office, it is essential for both the doctor and the patient to be working toward the same objective. Chiropractic science identifies the body as a self-healing and self-regulating being that is consistently adapting to its environment. This is achieved primarily through the central nervous system. Chiropractic has only one goal: to remove nervous system interference in the form of vertebral subluxation, thus restoring and maintaining the integrity of the spinal cord and its nerve roots.

There are vital communication pathways, essential for proper health, which travel to every organ, tissue and cell in the body, including the immune system. Chiropractors use specific chiropractic adjustments to reduce and remove nervous system interference, done either by hand or by instrument. This allows the proper flow of informational messages from the brain along these nerve pathways to every part of the body. This is critical for optimal health and well-being.

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.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation, nor do we offer advice regarding treatments prescribed by others. However, if during the course of your chiropractic care we encounter non-chiropractic or unusual findings, we will advise you on a possible referral. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of someone who specializes in that area. Be advised this will not interfere with your current chiropractic care plan.

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)

Signature of Chiropractor