TOTAL BODY CHIROPRACTIC
PEDIATRIC HEALTH HISTORY FORM

Welcome and Thank you for trusting us with your child!

Name: _____ Date: _____

Birthday (M/D/Y): _____ MSP #: _____

Parents/Guardian Names: _____

Address: _____

Email: _____ Join our Newsletter: Yes or No

Phone # : _____ Other # _____

How did you hear about us: _____

HEALTH STATUS

Purpose of this appointment: _____

_____

What do you feel is the cause of your child's problem?_____

_____

When did you first notice this sign of body dysfunction? _____

_____

Is this dysfunction getting progressively worse? __Yes __No
If yes, why do you think so?

_____

What are the most significant measures you have taken to date to improve your child's present health challenge? Please list all the healthcare practitioner's seen, treatments rendered, and any results experienced.

_____
_____
_____

Please list the (3) most significant stressful events in your child's life from the most recent to the most distant. Are any of these situations continuing to impact his/her life? If yes, please explain clearly (trauma, emotional distress etc.)

_____
_____
_____

Please list any and all other concerns regarding your child's health and whether or not you feel they are related to your child's primary reason for being seen in our office today.

_____

_____

_____

Please check **ALL** that apply:

___ Allergies	___Freq. colds/ congestion	___Upper respiratory Infections	___Asthma
___Ear infections	___Infected/ sore Throat	___Tonsillitis	___Laryngitis
___Colic	___Reflux/spit-ups	___U-tract infections	___Poor appetite
___Poor digestion/ (constipation/diarrhea)	___Thrush mouth/Chronic diaper rash	___Eczema/psoriasis/ Other skin rashes	___ADD/ADHD
___Irregular sleep Patterns	___Night terrors	___Bed wetting / Freq Urination	___Headache
___Anxiety	___Mood swings	___Bruising	___ Epilepsy/ Seizures
____ Pneumonia	____ Whooping cough	___ Chicken pox	___ Arthritis
___ Scoliosis	____ Behavior problems	___ Anger /Violent	___ Trouble focusing

Did you know that the persistent use of antibiotics can lead to an early onset of gastrointestinal tract distress leading to overgrowth of intestinal yeast? Did you also know that chronic use of antibiotics can lead to antibiotic resistant bacteria?
Please list any and all prescription medications that your child is presently using and has used on more than one occasion. Please reflect carefully as your child's present health state may be related directly or indirectly to the treatment of a past problem.

_____

_____

_____

_____

Each year a growing number of children are hospitalized due to acetaminophen and ibuprofen poisoning. Has your child taken any of these products that contain these chemical? ___ Yes ___No
If yes, for what reason and for how long? _____

Has your child ever been hospitalized? ___ Yes ___No
If yes, why and when? (Please list in chronological order, include all surgeries) _____
_____

Please list any and all injuries experienced by your child, how they occurred and what action was taken to correct them. (Major falls, broken bones, concussion etc..)

_____

_____

_____

HISTORY OF CHILD'S BIRTH

Birth weight: _____ Birth Length: _____

Type of Birth: □ Vaginal □ Caesaren □ Forceps □ Breech □ Vacuum
□ Home □ Hospital

□ Midwife □ Family Physician: Name: _____

Length of delivery: _____

Any Complications during Delivery: _____

At birth was there jaundine or cyanosis (blue colour)? _____

Do you remember the APGAR score at birth? (score is out of 10) _____

Any congenital anomalies or birth defects? _____

INFANT FEEDING

Was your child breast-fed? __Yes __ No If yes, for how long? _____

How was latching at birth: _____

Was your child formula fed? __Yes __No If yes, what type and for how long?
_____

At what age did you introduce solid foods into your child's diet? _____
What type(s)? _____

Has your child exhibited any tolerance and/or allergy to any specific food? __Yes __No
If yes, please list all foods._____
_____

Has your child been tested for allergies? __Yes __No
If yes, how were the tests performed_____
Results? _____
If so how does it present itself? (Skin rash, hives, digestion / respiratory issues)
_____
_____

QUALITY OF SYSTEMS

Quality of sleep: _____

Quality of Bowel movements: _____

Immunization history: _____

Please check any of the following sports activities that your child is engaged in.

___ Football	___ Lacrosse	___ Soccer	___Track/Field
___ Bowling	___ Tennis	___ Hockey	___ Volleyball
___Baseball/Softball	___ Skateboarding	___Snowboarding	___ Skiing
___Gymnastic/Trampoline	___BMX/Motorcross	___ Swimming	___Golfing
____ Skating	____ Horse riding	____ Rowing	___ Dance

Has your child ever been injured while playing sports? ___ Yes ___No
If yes, what type of injury(s) occurred?

_____

_____

FOOD INTAKE

Recent research reveals that 31% of Canadian children are obese.
On a scale from 1 – 5, please rate the food groups that are most eaten by your child on a daily basis. Use the higher number for the most common foods eaten.

_1 _2 _3 _4 _5	_1 _2 _3 _4 _5	_1 _2 _3 _4 _5	_1 _2 _3 _4 _5
Non-Complex Carbohydrates **Bread Products, Cereals, Pizza, Cakes, Cookies, Chocolate, Candy**	**Complex Carbohydrates** Fruits & Vegetables	**Protein** Nuts, Seeds, Meats, Eggs	**Fats** Dairy Products

Please list the (3) most common foods eaten by your child each day.

_____

How many times per month does your child eat fast food? _____
What type? _____

What is the primary beverage consumed by your child? _____

How much water does your child drink each day? _____

Does your child drink soda? ___ Yes ___ No If yes, how much on a daily basis? _____

TOTALBODY HEALTH

CONSENT TO CHIROPRACTIC TREATMENT

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

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.

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.

I acknowledge it is my responsibility to pay the fees as set out, for the Chiropractic Services at the time services are rendered. First visit is $150 and Subsequent Visits are $70. Extended treatments if necessary are charged accordingly. 24hrs notice is required to cancel an appointment. There will be a cancellation fee of 80% of the appointment fee for any missed appointments or late cancellations.

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)

_____ Date: _____ 20____
Signature of Chiropractor