Balanced Health and Sports Therapy

Chiro ● Physio ● Massage

PEDIATRIC (0m to 3yrs) 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 Name: _____ Parent's Cell No(s): _____
Pre-School or Day Care Attending: _____
Pediatrician: _____
How did you hear about us? _____

Birth Weight____ Current Weight ____ No. of Siblings? ____
Birth Length____ Current Length____

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? _____
Type of birth? (Please Circle) A vaginal birth, C-Section, Water Birth
Was any of the following tools used:(Please Circle) Vacuum (suction) Forceps
Location of birth: Home __ or Hospital__
APGAR score at birth: _____
Jaundice (yellow): _____ Cyanosis(Blue): _____
Congenital anomalies/defects ☐Yes ☐No
If yes please explain: _____

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Feeding History:
Was your child breastfed? _____ If yes, how long? _____
Formula? _____ Type? _____
Number of house sleeping per night___ Quality of Sleep (Please Circle)
Good, Fair or Poor
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:
_____

Has your child ever suffered from? (Please Circle)

Dizziness	Neck Problem	Asthma	Chronic Ear
Behavioral	Fainting	Growing Pains	Aches
Problems	ADHD/ADD	Arm problems	Diabetes
Poor Appetite	Constipation	Back Aches	Scoliosis
Broken Bones	Seizures	Walking	Allergies
Stomach	Leg problems	Trouble	Bed Wetting
Aches	Reflux	Sinus Trouble	Other_____

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: _____

Can your child do the following? (Please check what applies)

__Respond to Sound	__Follow and object with his/her eyes	__Hold head up
__Sit alone		__ Stand
__Crawl	__ Walk alone	

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? _____

Has your child ever suffered from the following spinal traumas?
Fallen from… Please check the following that apply.

__Baby walker	__Skateboards or Skates	__Change table
__Bed		__ Slide
__Monkey Bars	__High chair	__Down Stairs
__Crib	__ Swing	
__Couch	__Bicycle	

Has your child experienced any other injuries? _____

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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: _____

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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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 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 MEETWITH 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.

_____ Date: _____ 20____.
Name (Please Print)

_____ Date: _____ 20____.
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor