**Courtenay Family Chiropractic**
***Exceeding Above & Beyond***
***Your Health Expectations***

# Child and Pediatric Health History Form

*Please complete the following as completely as possible. If you need assistance, please ask the front desk staff and they will be glad to assist you.*

Child's Name: _____ Today's Date: _____

Parent(s) Name: _____

Address: _____
Residence and Mailing City Province Postal Code

Home Tel:( ) _____ Cell: ( )_____

Work Tel:( )_____ BC Care Card #: _____

Email: _____ Birth date: (mm/dd/yy) _____

(your Email will NEVER be used outside this office)

Has your child had previous chiropractic care? ☐ Yes ☐ No Chiropractor's name: _____

Date of last adjustment: _____Medical Doctor's name _____

Who may we thank for referring you to our clinic? _____

Does your child have **extra (extended) health insurance**? ___ Yes ___ No

Has your child ever been in a car accident? ___ Yes ___ No Is this an ICBC related visit? ___ Yes ___ No

## Why This Form Is Important:

In this clinic our focus is on helping people to function optimally so that they are stronger, healthier and better able to adapt to the stresses of everyday life. This form gives us a better understanding of the physical, chemical and emotional stresses that can gradually accumulate over time to produce health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

## History of Birth

What was the child's gestational age at birth? _____ Weeks.

Birth weight: _____lbs._____ oz.

Was your child's birth ☐ at home ☐ in a birthing center ☐ in a hospital

Was the birth considered: ☐ medical ☐ midwife

What was the duration of the labour and birth?_____ hours

Was child born: ☐ Cephalic (head first) ☐ Breech (feet first)

Were there any complications? ☐ Yes ☐ No If yes, please explain _____

_____

Please check any assistance that was used during the birth:

☐ Forceps ☐ Vacuum Extraction ☐ C-Section ☐ Episiotomy

Was labour: ☐ Spontaneous ☐ Induced

Were medications or epidurals given to the mother during birth? ☐ Yes ☐ No If yes, what was given?

_____

## Growth and Development

Was the infant alert and responsive within 12 hours of delivery? ☐ Yes ☐ No If no, please explain _____

_____

Are you aware of any developmental delays in your child? ☐ Yes ☐ No If yes, please explain _____

_____

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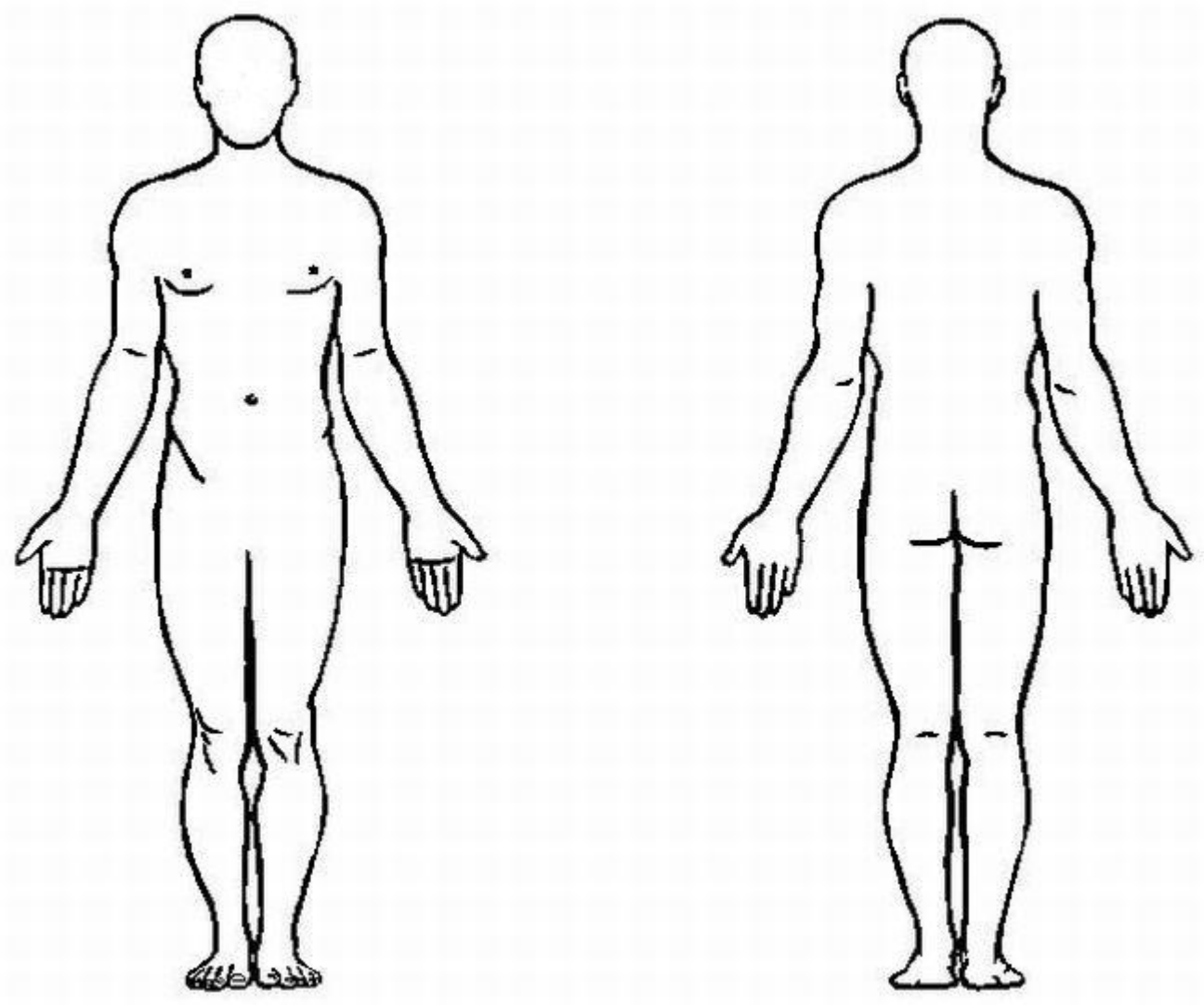
In the diagrams provided below, please mark the areas of your body which you feel best represent the pain(s)/discomfort(s) or sensation(s) you (or your child) are experiencing**. Please include <u>all</u> areas**. Use the symbols provided below. Also, in order to complete the picture, please draw in your face.

SYMBOLS:

| | | | |
|---|---|---|---|
| llll | numbness | •••• | pins and needles |
| //// | burning | = = | stabbing & sharp |
| xxx | dull & aching | +++ | stiff & tight |



*If your child has **no** symptoms or complaints and is here for **wellness** services, please check (√) here _____ and skip to "**Seemingly Unrelated Symptoms**"*

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## Present Health Complaints/Concerns:

Major: _____

Minor: _____

When did this problem begin? _____

Is this problem: ☐ Occasional ☐ Frequent ☐ Constant ☐ Intermittent

Does this problem radiate? ☐ Yes ☐ No If yes, to where? _____

What makes this worse? _____

What makes this better? _____

Is the problem worse during a certain time of the day? ☐ Yes ☐ No If yes, when? _____

Does this interfere with the child's ☐ Sleep? ☐ Eating? ☐ Daily Routine?

Is this becoming worse? _____

Other professionals seen for this condition? _____

Results with that treatment? _____

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## Seemingly Unrelated Symptoms can often manifest as other health concerns: (please check if your child has had **any** of the following)

| | | | |
|---|---|---|---|
| ☐ Headaches | ☐ Loss of Taste | ☐ Weight Loss/Gain | ☐ Neck Pain |
| ☐ Dizziness | ☐ Light Sensitivity | ☐ Dental Problems | ☐ Upper Back Pain |
| ☐ Fainting | ☐ Face Flushed | ☐ Fevers | ☐ Lower Back Pain |
| ☐ Fatigue | ☐ Cold Sweats | ☐ Heart Palpitations | ☐ Radiating Pain |
| ☐ Irritability | ☐ Bronchitis | ☐ Chest Pressure | ☐ Neck/Back Stiffness |
| ☐ Depression | ☐ Pneumonia | ☐ Breast Pain | ☐ Reduced Mobility |
| ☐ Loss of Balance | ☐ Difficulty Breathing | ☐ Frequent Colds/Flus | ☐ Numb in Arms/Hands |
| ☐ Loss of Concentration | ☐ Shortness of Breath | ☐ Sinus Congestion | ☐ Numb in Legs/Feet |
| ☐ Loss of Memory | ☐ Asthma | ☐ Sore Throats | ☐ Emotional Stress |
| ☐ Ears Buzzing | ☐ Urinary Problems | ☐ Ear Pain / Infections | ☐ Weakness |
| ☐ Poor Coordination | ☐ Constipation | ☐ Allergies | ☐ Muscle Cramps |
| ☐ Vision Changes | ☐ Diarrhea | ☐ Upset Stomach | ☐ Cold Hands/Feet |
| ☐ Mood Swings | ☐ Menstrual Pain | ☐ Heartburn | ☐ Sleeping Problems |
| ☐ Loss of Smell | ☐ Menstrual Irregularities | ☐ Bloating/Gas | ☐ Anxiety |

☐ Other: _____

## Family Health History

Please note any health issues with family relations:

Brothers: _____

Sisters: _____

Father: _____

Mother: _____

Grandparents: _____

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In this clinic we will perform a thorough assessment of your child's spine to locate areas of **Vertebral Subluxation**. Subluxations are the areas of dysfunction in the spine that interfere with the healthy connection between the nervous system and all the different parts of the body. This will result in compromised health and reduced energy to the tissue which that part of the nervous system supplies. Subluxations are caused by *physical, chemical* and *mental/emotional* stresses that overwhelm the nervous system and spine. Please complete this form to the best of your ability. This will help us to determine the causes of the subluxations we may find.

## Physical Stressors

Any significant falls or trauma to the mother during pregnancy? ☐ Yes ☐ No ☐ Unsure

Any evidence of birth trauma to the infant?

☐ Bruising ☐ Odd Shaped Head ☐ Stuck In Birth Canal

☐ Fast Or Excessively Long Birth ☐ Respiratory Depression ☐ Cord Around Neck

For the child, were there any falls from couches, beds, change tables, etc? ☐ Yes ☐ No ☐ Unsure

Any hospital visits for concussions, possible fractures or other traumas? ☐ Yes ☐ No ☐ Unsure

Have there been any surgeries? ☐ Yes ☐ No

If yes, please explain: _____

Is a backpack worn? ☐ Yes ☐ No If yes, is it ☐ heavy or ☐ light?

Does your child participate in sports? ☐ Yes ☐ No What? _____

Any hobbies or activities which require prolonged, awkward or repetitive postures? (i.e. violin, gymnastics, etc.)

☐ Yes ☐ No ☐ Unsure

## Chemical Stressors

Was this child breast-fed? ☐ Yes ☐ No If yes, how long? _____

Formula introduced at what age? _____ What formula? _____

Introduction of cow's milk at what age? _____

Food / Juice intolerance? ☐ Yes ☐ No If yes, what type? _____

During pregnancy, did the mother, smoke? ☐ Yes ☐ No How much? _____

drink? ☐ Yes ☐ No How much? _____

Any illnesses during the pregnancy? ☐ Yes ☐ No If yes, what illnesses? _____

_____

Any supplements taken during pregnancy? ☐ Yes ☐ No If yes, what supplements? _____

_____

Any drugs taken during pregnancy? ☐ Yes ☐ No If yes, what drugs? _____

_____

Any ultrasounds? ☐ Yes ☐ No How many and reasons for being done? _____

_____

Any invasive procedures during pregnancy (Eg. Amniocentesis, CVS, etc.)? ☐ Yes ☐ No Please explain: _____

_____

Any pets at home? ☐ Yes ☐ No If yes, what kind(s)? _____

Any smokers in the home? ☐ Yes ☐ No

## **Chemical Stressors** (cont.)

Vaccinations and age given? _____

Any negative reactions? ☐ Yes ☐ No If yes, what were they? _____

Any antibiotics given? ☐ Yes ☐ No Reason? _____

## Psychosocial Stressors

Any difficulties with nursing? ☐ Yes ☐ No If yes, what are they? _____

Any difficulties bottle feeding? ☐ Yes ☐ No If yes, what are they? _____

Any problems with bonding? ☐ Yes ☐ No If yes, what are they? _____

Any behavioral problems? ☐ Yes ☐ No If yes, what are they? _____

Any ☐ night terrors ☐ sleep walking ☐ difficulty sleeping

Age of child when he/she began daycare? _____

Average number of hours of television per week? _____

Do you feel that your child's social and emotional development is normal for their age? ☐ Yes ☐ No

If no, please explain:

_____

_____

Thank you for completing this health history for your child. If you have any other questions or concerns please write them in the space below, otherwise, **please turn to the next page.**

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## Informed Consent to Chiropractic Treatment

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. Recent studies suggest 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)**

**********

Dr. Ken Heinrich Dr. Marnie Grant

**Courtenay Family Chiropractic**
447 11th Street
Courtenay, BC
V9N 1S5