West Edmonton Family Chiropractic

Chiropractic Pediatric History Form

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Certain stresses in your life start to produce layers of damage to your spine and nervous system. Please answer the following questions to the best of your ability.

Name: ____ Date: _______________ AHC# _________________________

Address: ______________________________________ City/Prov:_____________________ Postal Code:____________

Age:______ Birth Date: (mm/dd/yr) ______________ Gender: M F

Name of Parents/Guardians:____ Home #__________ Work #__________

Who may we thank for referring you to our office: ____

Previous Chiropractor: ____
Date of last visit: ____________ Reason: _____________________________________

Name of Pediatrician: ____
Date of last visit: ____________ Reason: _____________________________________
Are you satisfied with the care your child has received there? Y N

Purpose for contacting us: ____

Have you seen other Doctors for this condition? Y N
If yes, please list names and prior treatments: ____

Has your child ever been hospitalized or had surgery? ____

Check any of the following conditions your child has suffered from during the past six months:

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Chronic Colds	☐ Headaches
☐ Asthma / Allergies	☐ ADD/ADHD	☐ Colic	☐ Growing pains	☐ Bed Wetting
☐ Digestive Problems	☐ Back Pains	☐ Car Accident	☐ Temper tantrums	☐ Sleeping Difficulties
☐ Recurring Fevers	☐ Poor Posture	☐ Other: ______________________		

Childhood Diseases:								
	Chicken Pox	N	Y	Age _____	Mumps	N	Y	Age _____
	Rubella	N	Y	Age _____	Whooping Cough	N	Y	Age _____
	Rubeola	N	Y	Age _____	Other	N	Y	Age _____

Family health history: ____

Number of doses of antibiotics your child has taken:
During the last six months: _______ Total during His/Her lifetime: _______

Number of doses of Other Prescription Medications your child has taken:
During the last six months: _______ List: ____
Total during His/Her lifetime: _______ List: ____

Vaccination history:
What vaccinations and age given? ____________________

Any negative reactions? N Y List: ____________________

Reason for vaccination? ☐ Informed decision ☐ Didn't know I had a choice ☐ Recommended

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According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? Y N

Is/has your child been involved in any high impact or contact sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? Y N List: ____________________

Any other traumas not described above? Y N List: ____________________

Complications during delivery? Y N List: ____________________

Birth interventions? ☐ Forceps ☐ Vacuum extraction ☐C-section ☐Other____________________

Feeding history:
Breast fed: Y N How long?__________
Formula fed: Y N How long?__________
Food allergies or intolerances: Y N List:____________________

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 make you and your family feel more comfortable. We look forward to working with you to build better health for your family.

AUTHORIZATION FOR CARE OF A MINOR

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

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND 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 care. 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 statement and consent to treatment.

Print Parent/Guardian Name: ____________________ Signature: ____________________

Witness: ____________________ Date signed: ____________________