HEALTH FIRST CHIROPRACTIC
Dr. Marty Thompson Chiropractic Corporation

Today's Date:_____

PEDIATRIC HEALTH HISTORY (12 & UNDER)

Childs Name: L:_____ F:_____ Sex: M / F

Parents: _____ Number of Children: _____

Address: _____City_____ Province: _____ Postal Code: _____

Home Phone :(____)_____ Cell: :(____)_____ Date of Birth: M____/ D____/ Y____ Age: ____

Medical Doctor: _____ last visit to MD: _____

Emergency Contact: _____Phone :(____)_____ Relationship:_____

How do you hear about our office? _____

Health Care #:_____ has your child ever received chiropractic care? Yes / No

If yes, Dr._____ Approx. date of last Visit: _____

Present reason for consulting our office:

☐ maximizing personal and/or family health potential?

☐ Correction and prevention of an existing problem? *Please fill out the information below.*

If your child has symptoms or a complaint, briefly describe the problem here. _____

_____

How and when did this problem start? _____

The problem is: Constant _____ Comes and goes _____ Radiates/Travels (where) _____

If he/she is experiencing pain, is it: Sharp ____Dull___Throbbing _____Aching _____ Shooting _____Nagging _____ What aggravates the condition/pain?_____

Please describe any past or current treatment(s) and results: _____

EVENTS

There are many events that occur throughout childhood- starting with childbirth, then learning how to walk, and playing childhood sports. These events can cause accumulated stress and results in loss of health potential. A child's spine is like a growing tree- "As the twig is bent, so grows the tree." Most times the effects are gradual, not even felt until we become adults. Answering the following questions will give us an understanding of your child's overall health and allow us to better assess their body's innate ability to be healthy. Please check off the following.

Tell us about your pregnancy:

Did you carry to full term (40 weeks)? _____ If not, how many weeks gestation? _____

Did you consume alcohol during your pregnancy? _____ did you smoke? _____

Did you take any medications during your pregnancy? Details: _____

Describe any complications and when they occurred:_____

_____

Tell us about your labor and delivery of the child:

Did you use a midwife? _____ Obstetrician? _____ Home Birth?_____ Hospital?_____

Did you have a C-Section? _____ Vaginal Birth? _____

Were you induced? _____ Epidural? _____ Were forceps used? _____ Vacuum Extraction? _____

What was the baby's **APGAR** score at 1 minute? _____/10 & at 5 minutes?_____/10 **OR** not sure:_____

Any initial respiratory delay? _____ Purple markings on face?_____ Mis-shaped skull?_____ Jaundice?_____

Describe and problems during labor and delivery:_____

Tell us about your child: Did you breastfeed? _____ How long? _____ Bottle feed? _____ Formula? _____
Number of hours your child sleeps per night? ____hrs Quality of sleep? good_____ fair_____ poor_____
Was your child vaccinated?_____ List any vaccine reactions:_____
List any <u>current</u> medications or supplements your child is taking:_____
List and <u>previous</u> medication(s), for what condition and the number of times it was prescribed:_____
List any emergency visits: _____

As a baby/toddler (birth-4 years), did any of the following occur?

____Fall from change table/crib
____Tumble down stairs
____Involved in a car accident
____Play in "Jolly Jumper"
____Fall off playground equipment
____Constipation
____Frequent ear infections
____Reaction to Vaccination
____Bed Wetting
____Frequent Fevers
____Frequent bouts of diarrhea
____Did not gain weight
____Sleeping problems
____Frequent Colds
____Colic
____Other_____

As a young child (5-12 years), did any of the following occur?

____Fall from tree/playground equipment
____Fall off bicycle
____Sports Accident
____Car Accident
____Stomach Pains
____Scoliosis
____Learning Difficulties
____Bed Wetting
____Hyperactivity/Autism
____Asthma
____Allergies
____Leg/knee Pains
____Frequent Colds
____Other_____

SYMPTOMS AND ILL HEALTH

As a child or adolescent, has your child experienced any of the following?

____Headaches
____Dizziness
____Ringing in Ears
____Asthma
____Hyperactivity
____Weight Gain/Loss
____Arm/Wrist Pain
____Neck/Back Pains
____Sleeping Problems
____Allergies
____Stomach Problems
____Other:_____
____Foot/Ankle/Knee Pains
____Tingling in Arms/Legs
____Shoulder Pains
____Fatigue
____"Growing Pains"

OFFICE USE ONLY

BWD L _____ R _____
FTN: + -
BALANCE TEST: + - (R / L)
MITTLEMEYERS: + - (FORWARD/ R / L)

ROM: C-SPINE:

Rot R (N ↓ (with pain/without pain) _____
Rot (N ↓ (with pain/without pain) _____
Lat R (N ↓ (with pain/without pain) _____
Lat L N ↓ (with pain/without pain) _____
Flex (N ↓ (with pain/without pain) _____
Ext (N ↓ (with pain/without pain) _____

T-L SPINE:

Rot R (N ↓ (with pain/without pain) _____
Rot L (N ↓ (with pain/without pain) _____
Lat R (N ↓ (with pain/without pain) _____
Lat L (N ↓ (with pain/without pain) _____
Flex (N ↓ (with pain/without pain) _____
Ext (N ↓ (with pain/without pain) _____

Dr. use only
Carotid Artery auscultation Bruits Yes/No

N=Normal/↓ = decreased

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 rather, recent studies indicate 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 (please print) Name (please print)

EMAIL CONSENT FORM

Health First Chiropractic is constantly trying to improve our service to our valued patients. In relation to new laws in Canada regarding electronic messaging we are asking your permission to send you electronic messages from time to time, primarily for appointment reminders, but also periodically monthly educational information and or promotional materials. If at any time you wish to cancel this service you can reply "UNSUBSCRIBE" and we will delete your email address from our system.

I _____ _____ give consent to Health first chiropractic to communicate with me via email or electronic messaging. I understand that I can unsubscribe from this at anytime by replying "UNSUBSCRIBE".

EMAIL _____

Printed Name _____

Signature _____

Date _____

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