Patient Name: _____ *Date:* _____

AHC #: _____ ***(required by the Alberta College of Chiropractors)***

Email Address: _____

Under Canada's new anti-spam legislation, we are required to ask you for your consent to contact you via email for appointment reminders and information regarding your health. Do you consent? _____ (YES) _____(NO) _____

Sign or Initial here

Beacon Hill Chiropractic and Massage reserves the right to charge a fee for missed appointments _____

Sign or Initial here

Children's Health Record

Relax • Breathe • Smile ☺

We are happy you are here!

As a full spectrum Wellness Centre, we focus on your child's ability to be healthy. Our goals are firstly, to address the issues which brought your child into our office, and secondly to offer your child the opportunity of improved health potential as he or she continues to grow and develop. On a daily basis, children experience physical, chemical and emotional stress which can accumulate and result in a loss of health and compromised function. If these stressors are not addressed, they may affect your child's development well into adulthood. Answering the following questions will provide us with a profile of the specific stressors your child faces, allowing us to better assess the challenges to your child's health.

BEACON HILL
CHIROPRACTIC AND MASSAGE
~NORTHWEST~

About Your Child

Child's Name: _____ Age: _____ Birthdate M/D/Y: _____ □ M □ F

Parent's Name: _____

Address: _____ City: _____ Prov: _____ PC: _____

Phone (h): _____ Phone (c): _____ Phone (w): _____

# of Children in family: _____ Parents: □ Married □ Single □ Divorced □ Separated □ Widowed

Parent's Employer: _____

Alternate Person to Contact In Case of Emergency:

Name: _____ Phone Number: _____(h) _____(c)

Reason For This Visit

Describe the purpose of this visit: _____

Is this visit related to: □ School □ Sports □ Auto Accident □ Fall □ Chronic Discomfort □ Injury □ Other

Please explain: _____

When did this condition begin? _____

Has this condition: □ gotten worse □ gotten better □ stayed the same □ comes and goes

Does this condition interfere with: □ work/school □ sleep □ daily routine □ athletic activities

Explain: _____

Have you seen anyone else for this condition? □ Y □ N

Doctor or Clinician's Name: _____

Type of Treatment: _____

Result: _____

Family Health History

☐ Diabetes ☐ Depression ☐ MS ☐ Heart Disease ☐ Osteoporosis ☐ Stroke ☐ High Blood Pressure
☐ Arthritis ☐ Cancer ☐ Adverse Vaccine Reactions ☐ Digestive Issues/Irritable Bowel
☐ _____

Child's Current Health Status

Is your child accident prone? ☐ No ☐ Yes

Has your child

. . . been hospitalized? ☐ No ☐ Yes

Explain _____

_____

. . . had a severe fall? ☐ No ☐ Yes

. . . been in a car accident? ☐ No ☐ Yes

. . . had a severe illness? ☐ No ☐ Yes

Explain _____

_____

. . . had a surgery? ☐ No ☐ Yes

For what? _____

_____

Has your child taken antibiotics? ☐ No ☐ Yes

If "yes", explain_____

Is your child currently taking any medication? ☐ No ☐ Yes

If "yes", explain _____

Does your child have difficulty interacting with schoolmates or friends? ☐ No ☐ Yes

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? ☐ No ☐ Yes

What changes (if any) in your child's health or behavior would you like accomplished _____

_____

Experience with Chiropractic

Who referred you to our office?

_____

Have your child ever been adjusted by a Chiropractor? □ Y □ N

Reason for visits? _____

How long ago? _____

Doctor's Name?_____

Date of last visit? _____

Has any **adult** in your family seen a Chiropractor? □ Y □ N

Has any **child** in your family seen a Chiropractor? □ Y □ N

Were you aware that:

- Doctors of Chiropractic work with the nervous system? □ Y □ N
- The nervous system controls all bodily functions and systems? □ Y □ N
- Chiropractic is the largest natural healthcare profession in the world? □ Y □ N
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout your whole life? □ Y □ N

Mother's Pregnancy and Labor

How was Mother's Pregnancy? _____

During pregnancy, did mother

. . . take any medication? ☐ No ☐ Yes Explain _____

. . . smoke or consume alcohol? ☐ No ☐ Yes How often _____

. . . experience any illness? ☐ No ☐ Yes Explain _____

Approximately how long did labor last? _____ Hours

Was labor doctor assisted? ☐ No ☐ Yes

Were forceps or vacuum extraction used? ☐ No ☐

If "yes", at _____ month and _____ weight

Was labor chemically induced? ☐ No ☐ Yes

Was a C-Section performed? ☐ No ☐ Yes

Was the delivery premature? ☐ No ☐ Yes

Check any of the following if the child experienced it immediately after birth:

☐ Jaundice ☐ Respiratory problems ☐ Feeding problems ☐ Displaced or broken joints

☐ Failure or Minimal Crawling ☐ Sleep or nurse favoring one side

Health Systems Review

Please check each of the diseases or conditions that your child has now or has had in the last 6 months.

☐ Headaches	☐ Tubes in Ears	☐ Ear Ache/Infection	☐ Urinary Tract Infection
☐ Arthritis	☐ Sinus problems	☐ Pink Eye	☐ Constipation
☐ Vison problems	☐ Frequent Colds	☐ Colic	☐ Motor Vehicle Accident
☐ Heart problems	☐ Constipation	☐ Loss of sleep	☐ Allergies
☐ Bed Wetting	☐ Digestive problems	☐ Irritability	☐ Asthma
☐ Foot/Gait Problems	☐ Developmental Delay	☐ Low energy	☐ Other

_____

_____

Vaccinations

Have you chosen to vaccinate your child? ☐ Y ☐ N

If "yes", check all vaccinations your child has received:

☐ DPT	☐ Hepatitis	☐ MMR	☐ German Measles	☐ Other
☐ Polio	☐ Gardasil	☐ Chicken Pox	☐ Flu Shot _____	

Describe any reactions (either immediate or delayed) to vaccinations: _____

_____

Goals For My Care

Children see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your child's needs and goals when recommending a treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ Relief Care – Symptomatic relief of pain or discomfort
- ☐ Corrective Care – Corrective and relieving the cause of the problem as well as the symptoms
- ☐ Comprehensive Care – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
- ☐ I want the Doctor to select the type of care appropriate for my child's condition

_____ _____

Patient Signature Date