בס"ד

A NATURAL PATH TO HEALTH
LIVE WELL

Pediatric Health Profile & History

Date: _____

Child's Name: _____ **DOB (D/M/Y):** _____ **Age:** _____ **Male** **Female**

Parent's Names: _____ **Number of siblings:** ____ **Pediatrician:** _____

Address: _____ **City:** _____ **Province:** ____ **Postal Code:** _____

Home : ( )_____ **Work: ( )**_____ **Cell: ( )**_____

Who may we thank for referring you to us? _____ **Email Address:** _____

Would you like appointment reminders sent via Email? **Yes** ____

Would you like statements sent to you automatically via Email? **Yes** ____

HEALTH PROFILE

Please briefly describe what brings you into our office today? _____

_____

When did you begin to notice this _____ It has been: getting better ___ worse____ the same____

How does this effect your child?_____

When is the problem worse/better?_____

Who have you seen for this condition? ___Chiropractor ___MD ___Physio ___ Other _____
Name(s) and approximately when : _____

What was the diagnosis and treatment provided: _____

HEALTH HISTORY

Labour & Delivery Full term ___ Preterm ___ Duration and difficulty _____

Antibiotics___ Forceps ___ Vacuum___ C-Section___ Other Complication_____

Early Infant Stages Significant health issues or concerns: _____

Breast fed___ Formula fed___ Difficulties nursing _____

Colic ___ Reflux___ Fussy___ Gassy___ Sleep problems___ Hard to handle___ Stiff when held___

Other health issues or concerns: _____

Infant to Toddler Transition

How long did he/she nurse? _____ When introduced to solids, cow's milk, etc _____

Developmental milestones: Roll over _____ Sit up_____ Crawl_____ Cruise_____ Walk_____

Number of ear infections_____ Number of times on antibiotics_____ Other meds_____

Sleeping difficulties_____ Upset or crying in: Car____ Loud public places___ Bath____

Other health issues or concerns: _____

Toddler to Young Child Significant falls or other stresses _____

Ear infections or other illnesses? _____ Number of occurrences ____ Interventions_____

Sleep issues _____ Behavioural issues_____

Other health issues or concerns: _____

Mother's significant medical history (including IVF) _____

_____

During pregnancy:

Mother's mental/emotional stress _____ Remodeling of home or moving _____

Any medical intervention/problems_____ Other potential stressors_____

CHILD'S CURRENT HEALTH STATUS

List all current and past significant health conditions, diseases and injuries, as well as past surgeries

_____

_____

List any medications your child is taking, and why _____

List any allergies your child has _____

Please check all appropriate symptoms even if they do not seem related to your current problem

Recent	Past		Recent	Past		Recent	Past	
❑	❑	Headaches/Migraines	❑	❑	Irritability	❑	❑	Anxiety
❑	❑	Dizziness	❑	❑	Repeated ear infection	❑	❑	Depression
❑	❑	Fatigue	❑	❑	Poor immune function	❑	❑	Mood swings
❑	❑	Sleeping problems	❑	❑	Fever	❑	❑	Loss of smell/taste
❑	❑	Tension	❑	❑	Urinary problem	❑	❑	General stiffness
❑	❑	Difficulty concentrating	❑	❑	Fainting	❑	❑	Back pain
❑	❑	Reflux/Heartburn	❑	❑	Eyes bothered by light	❑	❑	Neck pain
❑	❑	Stomach upset/Nausea	❑	❑	Diarrhea/Constipation	❑	❑	Stiff neck

STRESS PROFILE

Physical Stresses

List any sports related injuries: _____

List any significant slips, falls or auto accidents? _____

Emotional Psychological Stresses (Rate high or low)

School stresses: _____ Family/Relationship stresses: _____ Other stresses: _____

Nutritional Chemical Stresses On a scale of 1 to 10 (1=poor, 10 = excellent)

Water ____/10 Proteins ____/10 Healthy Fats ____/10 Fruits/Vegetables____/10

Is your child's diet high in: Sugar ____ Unhealthy snacks ____ Soda____ Processed foods____

Please rate the following: Exercise___/10 Sleep___/10

Which of the following supplements are taken regularly Omega 3 ___ Vit D ___ Probiotics___

List other supplements you give to your child _____

If there are any other health related issues that concern you, or anything else you would like to let us know, please do so here _____

_____

_____

Consent To Care

Dr. Weitz generally employs “tonal” instrument assisted Chiropractic techniques that do not involve rotational “manipulation” of the neck. These techniques allow the Chiropractic care provided to you to have a profound effect on your spine and nerve system through gentle taps without the use of forceful movements.

In general, Chiropractic care is safer than taking anti-inflammatories, pain killers, and virtually any other medication. There has been some concern about injury to the vertebral artery with extreme rotational movements of the neck being associated with stroke on rare occasion. Firstly, research and scientific evidence have not established a cause and effect relationship between Chiropractic treatment and the occurrence of stroke. Secondly, Dr. Weitz employs non-manipulative techniques, except in the event that you, the patient, explicitly request that other adjusting techniques be employed and that it makes clinical sense to do so. As with any manual therapy there is always the possibility of soft tissue strain or irritation, minor discomfort and short term aggravation of symptoms as nerve function improves, functionality changes and tissues balance.

Dr. Weitz does not diagnose disease or disease processes. His focus is on detecting, locating and correcting Vertebral Subluxation (spinal neural malfunction) in as gentle a manner as possible, to enable your body to function and heal to the best of its’ ability.

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 a professional and complete spinal-neural examination, including Insight scans that the Doctor deems necessary and to Chiropractic care offered or recommended to me by Dr. Weitz, including spinal adjustment. I intend this consent to apply to all my present and future care.

I will inform Dr Weitz of any changes in health status that occur between visits.

I understand that all fees for services rendered are due at the time of service and cannot be deferred to a later date. <u>Please note many of our patients prefer to leave a credit card number on file with us which we bill according to your express instructions</u>.

On behalf of_____, I have read the above & I hereby authorize Dr. Weitz, or such substitute as he may designate, to perform a complete spinal-neural examination and I consent to Chiropractic care recommended by Dr. Weitz or said substitute, including spinal adjustment.
I intend this consent to apply to all present and future care.

Dated this_____ day of _____, 20___

_____ _____ (Verified by: _____)

Guardian Signature Guardian Name (please print)