Child Information

Date ____________________ For Office Use Only: ID #:

Child's Name ____

Parent(s) Names

____

Siblings' Names and Ages

____

Address ______________________ City/Town ____________ Postal Code ________

Parents' E-mail Address

____

Would you like to receive our "Living Healthy" e-newsletter? ◯ Yes ◯ No

Date of Birth ______m/______d/______y/ Gender: ◯ Male ◯ Female

Home Ph ______________ Business Ph ______________ Mobile Ph ______________

Best time/ place to contact you? ______________________________

Whom may we thank for referring your child to this office? ______________________

Circle the phrase that most represents your child's reason for care:

◯ Wellness ◯ Prevention ◯ Feel good ◯ Symptom Relief

Reason for your child seeking services at our office: ______________________

Has your child ever seen a Chiropractor? If yes, who? Date of last visit: ______________

Name & Address of Obstetrician/ Midwife:

____

Name & Address of Primary Health Care Provider:

____

Date of last visit ______________ Purpose of visit ______________________

Health Concerns

Please list your child's heath concerns according to their severity:

Concern	Rate of Severity 1=mild, 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is pain present?
1.					
2.					
3.					
4.					

Pregnancy and Birth History

Gestational Duration: ___________ weeks

PHYSICAL STRESS

Trauma/Falls during pregnancy____

Any ultrasounds or other radiation? ○ Yes ○ No

How many and for what reasons? ____

Invasive Procedures (Eg. Amniocentesis, CVS) ? ○ Yes ○ No

CHEMICAL STRESS

During the pregnancy did the mother:

Smoke? ○ Yes ○ No How much? ____________________________

Drink Alcohol? ○ Yes ○ No How much? ____________________________

Prescription Medications? ○ Yes ○ No How much? ____________________________

Recreational Drugs? ○ Yes ○ No How much? ____________________________

Fall ill during pregnancy? ○ Yes ○ No please explain ____________________________

Were any supplements taken during the pregnancy? ○ Yes ○ No

Please list: ____

EMOTIONAL STRESS

Please rate your stress levels during pregnancy 1-10 (1= low, 10=high):____________________

LABOUR

Was labour induced? ○ Yes ○ No

Duration of labour? ____________________

Duration of active (pushing stage) labour?____________________

Did mother receive medications? ○ Yes ○ No

If yes, which: ____

BIRTH

Type of birth? ○ Vaginal: Cephalic (head first) ○ Breech (feet first) ○ C-Section

Location of birth? ○ Home ○ Hospital ○ Birthing center

Birth Assistants? ○ Midwife ○ Doula ○ Obstetrician

Was there any assistance needed during birth?

○ Forceps ○ Cesarean ○ Vacuum Extraction ○ Induction ○ Assisted Traction/Head Turning

Was delivery considered normal? ○ Yes ○ No

Were there complications during birth? ○ Yes ○ No

Please explain:

____

Was there any evidence of birth trauma to the infant? Check all that apply:

○ Bruising ○ Odd shaped head

○ Stuck in birth canal ○ Fast or excessively long birth

○ Respiratory depression ○ Cord around neck

Was your child subjected to any of the following? Check all that apply:

○ Silver nitrate drops in eyes ○ Incubation How long? ____________

○ Vitamin K shot ○ Separation from you How long? ____________

○ Hepatitis shot

Did your child spend any time in intensive care? Yes No If yes, how long? ______________

APGAR score at birth? ____________ APGAR score at 5 minutes? ______________________

Birth Weight? __________________ Birth Length? ______________________________

Childhood History

PHYSICAL STRESS

Does your child have a preferred sleeping position? ○ Yes ○ No ______________________________

Did your child prefer one-sided breast-feeding position? ○ Yes ○ No ______________________________

Did your baby spit up after feeding? ○ Yes ○ No ______________________________

Any falls or injuries down stairs, bicycle etc? ○ Yes ○ No ______________________________

Does child ever bang his/her head repeatedly? ○ Yes ○ No ______________________________

Any traumas resulting in bruises, fractures, stitches? ○ Yes ○ No ______________________________

Any hospitalizations or surgeries? ○ Yes ○ No ______________________________

Please list all surgeries your child has had:

1. Type ________________________________ When __________ Doctor ________________

2. Type ________________________________ When __________ Doctor ________________

Please list any accidents and/or injuries: auto, sports, or other (Especially those related to your child's present problems).

1. Type__________________________ When______________ Hospitalized? ○ Yes ○ No

2. Type__________________________ When______________ Hospitalized? ○ Yes ○ No

3. Type__________________________ When______________ Hospitalized? ○ Yes ○ No

Have you ever had x-rays taken? O Yes O No When?____________ Where?____________

What area of your child's body:____

Does your child play sports? O Yes O No ______________________________

If yes, hours per week? ______________ Age child began? ______________________________

Is school backpack used? O Yes O No Weight of backpack? ______________________kg/lbs

Approximate hours spent at play per week? ____

Average time spent at computer/TV/video games per week? ______ hrs

Does your child wear glasses or contact lenses? O Yes O No ______________________________

Does your child have trouble reading the board? O Yes O No ______________________________

Does your child have difficulty with coordination? O Yes O No ______________________________

CHEMICAL STRESS

Was/is child breast-fed? O Yes O No For how long? ______________________________

At what age was:

Formula introduced? ____________________________ Brand? ______________________________

Cow's milk introduced? ____

Solid food? ____

Food/juice intolerance? O Yes O No____

Does your child have food allergies? O Yes O No____

What is your child's favourite food? ____

What does your child regularly drink? ____

The type of diet your child usually follows is classified as: ______________________________

Please circle any dietary selection that is appropriate for your child, and grade according to the following scale:

Daily:
D - Consume this daily
FD - Consume this a few times per day

Monthly:
M - Consume this monthly
FM - Consume a few times per month

Weekly:
W - Consume this weekly
FW - Consume this a few times per week

Never:
O - Do not consume this

Eggs	____	Fasting	____	Fruit	____		
Fish	____	Diet Food	____	Organic Foods	____		
Coffee	____	Beef	____	Weight Control Diet	____	Raw Vegetables	____
Soft Drink	____	Poultry	____	Artificial Sweetener	____	Whole Grains	____
Fried Foods	____	Seafood	____	Cooked vegetables	____		
Refined Sugar		Dairy		Canned/Frozen vegetable			

Does your child have a bowel movement every day? ○ Yes ○ No ______________________

Does your child have regular or occasional skin rashes? ○ Yes ○ No ______________________

What vaccinations were given and at what age?

____

____

Reason for vaccinations ____

Were there any negative reactions? ○ Yes ○ No ______________________

Was there any:

○ Fever ○ Un-consolable crying

○ Irritability ○ Arching of body

○ Bowel disturbances ○ Feeding disturbances

○ Drowsiness ○ Other: ______________________

History of antibiotics? ○ Yes ○ No

If so, how many coursed of antibiotics has your child received in their lifetime? ______________

Reason and length of last course of antibiotics? ______________________________

Please list ALL medications your child currently takes or has taken in the past 6 months:

Name ______________________ Dosage _______ For what? ______________

Name ______________________ Dosage _______ For what? ______________

Name ______________________ Dosage _______ For what? ______________

Please list all nutritional supplements, vitamins, homeopathic remedies your child presently takes:

Name ______________________________ For what? ______________

Name ______________________________ For what? ______________

Are there pets in the home? ○ Yes ○ No ______________________

Are there any smokers at home? ○ Yes ○ No ______________________

EMOTIONAL STRESS

Did mother have any difficulties with breast-feeding?

Did mother and baby have difficulty bonding?

Did mother experience any post-partum depression?

Night terrors, sleep walking, difficulty sleeping ○ Yes ○ No ______________________

Do you consider their sleeping pattern normal? ○ Yes ○ No ______________________

Quality of Sleep? ○ Good ○ Fair ○ Poor Number of hours ______________

Behavior problems? ○ Yes ○ No ______________________

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

Does your child attend day care? ◯ Yes ◯ No From what age? ____________

GROWTH AND DEVELOPMENT

Was your child alert & responsive within 12 hours of delivery? ◯ Yes ◯ No

If no, please explain: ____________

At what age did your child:

Respond to sound?	________	Sit alone?	________
Follow an object?	________	Teethe?	________
Hold head up?	________	Crawl?	________
Vocalize?	________	Walk?	________

FAMILY HISTORY

Describe any medical family history on mother's side: (EG cancer, diabetes etc)

____

On father's side:

____

Does sibling's have any health concerns? ◯ Yes ◯ No

If yes, please describe: ____________

Informed Consent to Chiropractic Care

When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective.

Chiropractic care has one goal, to correct vertebral subluxations. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in a decrease in the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our method of correction is by specific adjustments of the neurospinal system.

Health: A state of optimal physical, mental, and social wellbeing, not merely the absence of symptoms.

I understand that my care at this office will be focused on the detection and correction of vertebral subluxations. I hereby request and consent to the performance of chiropractic adjustments and assessments. Understanding that every body has a different potential for wellness thus, the maximal results I will receive in this office cannot be predicted or guaranteed.

Chiropractic care is considered to be one of the safest and most effective forms of care. I understand and am informed that, unlike many other health care professions, the risks associated in receiving chiropractic care are extremely minimal. In recent years there have been rare incidents of injury to the vertebral artery during the course of care by medical doctors, physiotherapists and chiropractors. To put this in perspective, the risk of stroke in the general population is 0.00057%. The risk of stroke after a chiropractic adjustment is 0.00025%. The risk of death from taking an aspirin and/or other anti-inflammatory drugs is 0.04%.

It is not our goal or intention to diagnose, treat or attempt to cure any physical, mental, emotional symptoms. Our expertise is in health, wellness, healing and human physiology. However, if during the course of chiropractic care, we encounter unusual findings, we will bring these to your attention. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Please discuss care alternatives with attending chiropractor.

Our primary goal is to release life in the body, through the detection and correction of vertebral subluxations.

At this office, the privacy of your personal information is an essential part of our office providing you with quality care. We are committed to collecting, using and disclosing your personal information responsibly. Our office has a privacy policy that complies with federal law, which you may view at any time by asking our staff.

I, ______________________ have read and fully understand the above statements.
(PRINT NAME)

I have also had an opportunity to ask questions about its content. I therefore accept chiropractic assessments and care on this basis. I intend this consent form to cover the entire course of my care in this office with Dr. John Beech or other attending chiropractor.

____

(SIGNATURE) (DATE) (WITNESS)

Consent to assess and adjust a minor:

I, __________________________________, being the parent or legal guardian of

(PARENT/GUARDIAN NAME)

____________________________________ have read and fully understand the above terms

(CHILD'S NAME)

of acceptance and hereby grant permission for my child to receive a chiropractic assessment and chiropractic care. All people respond differently to care. We never promise a cure, but we do promise to do our best.

(Information released from: The National Center for Health Statistics USA, 1993 and A Risk Assessment for Cervical Manipulation vs. Non-Steroid Anti-inflammatory Drugs for the Treatment of Neck Pain, JMPT, Oct. 1995)