WESTWOOD FAMILY CHIROPRACTIC

PEDIATRIC HISTORY FORM

Today's Date: _____

MHSC REGISTRATION # (6 DIGIT) _____ **(9 DIGIT)** _____
First Name: _____ Last Name: _____
Male/Female (circle) Birthday (d/m/y): _____ / _____ / _____ Current Age: _____
Street Address: _____
City: _____ Province: _____ Postal Code: _____
Home #: _____ Parent Work #: _____ Parent Cell #: _____
Parent Work #: _____ Parent Cell #: _____
Parent Email Addresses: _____
Any Siblings? Y/N Names/Ages: _____
_____

CHIROPRACTIC HISTORY:
Has your child been to a chiropractor before? Y/N Date of last visit: _____
Name of last chiropractor: _____ Did they take X-rays? Y/N

Has your child ever been in a car accident? Y/N If yes, when? _____

Please check the choice that most closely describes your current goals for your child's health and wellbeing:

☐ I am only concerned about relief of a particular symptom, and preventing its return
☐ I want optimum health and wellbeing on every level available to my child

Main purpose for contacting this office? _____
_____

Medications:
Number of antibiotics in the past 6 months: ____ Lifetime: ____ Vaccinated: Y/N (circle)
Any reaction to vaccines? _____ Allergies/sensitivities to medications? Y/N
Please list ANY medication your child is currently taking: _____
_____

Prenatal History:
Obstetrician/Midwife/Doula (circle) Name(s): _____
Complications during pregnancy? Y/N list: _____
Medications during pregnancy? Y/N list: _____
Number of ultrasounds? _____ Exceptional stress during pregnancy? Y/N
Location of birth? ☐ Hospital: _____ ☐ Home ☐ Other: _____
During pregnancy, did mother? ☐Smoke ☐ Drink alcohol ☐ Have caffeine

Birthing Details:
☐Breech ☐Caesarian ☐ Forceps ☐ Vacuum ☐ Episiotomy ☐ Epidural☐ Natural
☐ Premature ☐ Medications during birthing process, list: _____
Apgar score: ____ Birth weight: _____ Generic disorders/difficulties: _____

Feeding History:
Breast fed? Y/N If yes, how long? _____ If no, formula type? _____
Age solids introduced? _____ Food allergies/sensitivities? _____

Developmental History:
Please let us know these stages have been reached by checking the box and providing at which age they occurred:
☐ Rolling over: _____ ☐ Sitting up without support: _____ ☐ Crawling: _____
☐ Standing with support: _____ ☐ Walking unassisted: _____
Has your child had any injuries/traumas/falls/accidents? _____
_____

Health History:
☐ Asthma ☐ Croup ☐ Ear infections ☐ Chronic colds ☐ Bronchitis ☐ Chicken pox
☐ Rubella ☐ Rubeola ☐ Mumps ☐ Whooping cough ☐ ADD/ADHD ☐ Allergies
☐ Bed wetting ☐ Colic ☐ Acid reflux

Anything else relating to your child's history that has not been addressed on this form:
_____
_____
_____
_____

Consent to Chiropractic Treatment Standard of Practice S-05

It's important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment. Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joint of the body, soft tissue techniques such as massage and other forms of therapy including, but not limited to, electrical or light therapy and exercise. Benefits Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasms. It can also increase mobility, improve functions and reduce or eliminate the need for drugs or surgery.

Risks
The risks associated with chiropractic treatment may vary according to each patient's condition as well as the location and type of treatment.

The risks include:
• **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days;

• **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar;

• **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the affected area and other minor care;

• **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention;

• **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
•**Stroke** –Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving neck movements have been associated with a stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care.

Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH YOUR CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks or treatment, as well as the alternative to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____ _____
Signature of Patient (or Legal Guardian) Date

_____ _____
Signature of Chiropractor Date