PEDIATRIC HEALTH HISTORY FROM 0-2 YEARS Date: _____

At Parascak Family Chiropractic we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you into this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. Daily, we experience physical, emotional, and chemical stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced throughout your lifetime, allowing us to better assess the challenges to your health potential.

Child's Name: _____

Address: _____ City: _____ Postal Code: _____

Date of Birth (M/D/Y): _____ Age: _____

Sex: □ M □ F Height: _____ Weight: _____

Extended Health Care: □ No □ Yes Alberta Health Care #: _____

Mom's Name: _____ Mom's Phone #: _____

Dad's Name: _____ Dad's Phone #: _____

Mom's/Dad's Email: _____,_____

Previous Chiropractor: _____Last Visit: _____

Referred to this office by: _____

PURPOSE OF THIS VISIT TO OUR OFFICE

□ Spinal screening □ Wellness care □ Accident/Fall □ Illness □ Other Health Problem: _____

1. Have any other Doctors been consulted for this condition? □ No □ Yes, please provide the Doctor's name(s) and types of treatments: _____

2. Other health problems you would like to discuss: _____

_____

3. Check any of the following conditions your child has suffered from during their lifetime:

□ Asthma/Allergies	□ Scoliosis	□ Recurring Fevers	□ Sleeping troubles	□ Back/Neck or "Growing" Pains
□ Ear infections	□ Diabetes	□ Headaches	□ Car Accident	□ Numbness or Tingling
□ Poor Appetite	□ Diarrhea	□ Seizures	□ Dizziness	□ Digestive Problems
□ Hyperactivity	□ Colic	□ Constipation	□ Stomach Aches	□ Learning Disabilities
□ Bed wetting	□ Fatigue	□ Chronic Colds	□ Temper Tantrums	□ Other: _____

_____

4. Family Health History: _____

5. Name of Family Physician: _____Clinic: _____

Date of Last Visit: _____Purpose: _____

6. Number of doses of *antibiotics* your child has taken:

During the past six months: _____Total during his/her lifetime: _____

7. Number of doses of *other prescription medications* your child has taken:

During the past six months: _____Total during his/her lifetime: _____

8. Please list the medications: _____

_____

9. Has your child been vaccinated? □ No □ Yes, please list: _____

CHILDHOOD DISEASES

Has your child had any of the following illnesses? (please indicate age if applicable)

□ Measles (Rubella) _____ □ Mumps _____ □ Rubella (German Measles) _____

□ Pertussis (Whooping cough) _____ □ Chicken pox _____ □ Other _____

PRENATAL HISTORY

1. Name of Obstetrician/Doctor:_____
2. Ultrasounds During pregnancy?_ □ No □ Yes, how many? _____
3. Was there any smoking during pregnancy? □ No □ Yes, how much? _____
4. Medications during pregnancy? □ No □ Yes, please List: _____
5. Complications during pregnancy? □ No □ Yes, please List: _____
6. Location of birth: □ Hospital □ Birthing Centre □ Home
7. Was an epidural given? □ No □ Yes
8. Type of birth: □ Vaginal □ Forceps □ Vacuum Extraction □ Breech □ Caesarean □ Planned □ Emergency
9. Complications during labour/delivery? □ No □ Yes Please List: _____
10. Birth weight: _____ Birth length: _____ APGAR scores: _____, _____
11. Genetic disorders or disabilities? □ No □ Yes Please List: _____

FEEDING HISTORY:

1. Breast fed? □ No □ Yes, How long? _____
2. Formula Fed? □ No □ Yes, How long? _____
3. Food allergies or intolerances? □ No □ Yes, Please list: _____
4. Introduced solid foods at _____ months. Introduced cow's milk at _____ months.
5. Does your child consume any foods containing: □ Caffeine □ Artificial sweeteners (ex: aspartame/nutrasweet)

DEVELOPEMENTAL HISTORY:

During the following times, your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of spinal nerve interference. (vertebral subluxation)

1. At what age was your child able to:
   Respond to sound _____. Follow an object with their eyes _____. Hold head up _____.
   Sit up _____. Crawl _____. Stand alone _____. Walk alone _____.
2. According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of their life (ex: bed, change table, down stairs, from shopping carts, etc.). Has your child experienced any of these traumas? Describe: _____
3. Has your child ever been treated on an emergency basis? □ No □ Yes, describe: _____
4. Any other injuries or falls that have not been described above? □ No □ Yes, describe: _____
5. Surgeries/Operations? □ No □ Yes, describe: _____

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief while others are interested in having the cause of the problem corrected.

Please check the type of care you desire for your child:

□ *RELIEF CARE* – is aimed at eliminating your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

□ *CORRECTIVE CARE* – differs from relief care in that its goal is to get rid of symptoms or pain while correcting the cause of the problem. Corrective care varies in its length of time, but is more lasting.

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 because 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, 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 child's 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.

Name: _____ Signature: _____

Date: _____ Witness: _____