Almonte Chiropractic Centre

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INFANT'S /CHILDREN'S QUESTIONNAIRE (Ages 0 - 13 years)

Name: _____ Client # _____

Mom's name: _____ Dad's name: _____

Siblings: _____ _____

_____ _____

Address: _____

Phone #:_____ Email: _____

Date of Birth: _____ Age: _____ Sex: F / M

Name of M.D: _____

Who can we thank for referring you to our office? _____

Why this form is important:

Our office focuses on your child's ability to be healthy. Our goals are to first address the issues that brought you and your child to this office, and second, offer the opportunity to improve your child's health potential in the future. *Life activities include events that cause damage*. This damage builds layer upon layer even to levels at which you may **not yet be aware**.

Research is showing that many of the health challenges that occur in life have their origins during the developing years, some starting at or before birth. We need to know health history, so we ask you to carefully and completely fill out this detailed and important form.

Labour and Delivery (Please check those that apply)

☐ Hospital with doctor ☐ Hospital with midwife ☐ Home with midwife

☐ Breach ☐ Caesarian ☐ Fetal Monitor Used

☐ Medications ☐ Forceps /Suction ☐ Chemical Induced

☐ Epidural

Name of Midwife / Doctor: _____

Length of Labour: _____

Length of Delivery: _____

Mom's Position During Labour: _____

Any Complications? Please describe: _____

Prenatal & Infant History

Number of Ultrasounds given during pregnancy: _____

Duration of pregnancy in weeks: _____ APGAR Score at birth: _____

Birth Length: _____ Birth Weight: _____

Please check any problems your child had at birth:

☐ Jaundice ☐ Cyanosis ☐ Choking

Other_____

Please check if any of the following applied to your child after birth:

☐ Medication ☐ Ventilator ☐ Surgery

☐ Erythromycin ☐ Circumcision ☐ Neonatal Unit

Other: _____

Nutrition

Please check if your child received any of the following within the first six months:

☐ Breast Milk ☐ Commercial Formula ☐ Cow's Milk

☐ Goat's Milk ☐ Solid Food ☐ Sweets

☐ Fruit Juice ☐ Vitamins ☐ Medications

Other: _____

Please list any medication your child has taken (prescription and/or over the counter) past or present:

_____

How many times has your child been on antibiotics? _____ For what? _____

Developmental History

If your child is younger than 2, please indicate which of the following milestones she/he has reached:

☐ Hold head up ☐ Sits up ☐ Crawls ☐ Stands alone ☐ Walks alone

According to National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ie: bed, changing table, down stairs, etc) was this the case with your child?

☐ Yes ☐ No Please describe the circumstances: _____

Has your child been involved in any high impact or contact sports (ie soccer, football, hockey, gymnastics baseball, marital arts, etc?) ☐ Yes ☐ No Please list: _____

Has your child ever been treated or admitted to the Emergency Room? ☐ Yes ☐ No
Please describe: _____

Other injuries or falls not described above? Please list: _____

Prior surgery ☐ Yes ☐ No Please list: _____

X-rays/ CT / MRI ☐ Yes ☐ No Please list: _____

Did you choose to vaccinate your child? ☐ Yes ☐ No Please list any reactions: _____

Has your child had/have any of the following?

☐ Measles (Rubeola) ☐ Mumps ☐ Rubeola (German Measles)

☐ Pertussis (Whopping Coughs) ☐ Chicken Pox ☐ ADHD

☐ Strep ☐ Colic ☐ Headaches

☐ Constipation ☐ Ear Infections ☐ Bed wetting

☐ Asthma ☐ Allergies ☐ Lactose intolerance

☐ Toe in/toe out ☐ Tonsillitis ☐ Other

Important Note:

Chiropractic has helped children with many health problems like asthma, allergies, bed wetting (nocturnal enuresis) colic, ear infections (acute and chronic) headaches, scoliosis, etc. Chiropractic care has also been shown to help prevent these and other illnesses from occurring and ensure children have a healthier life. To optimally prevent these, a child should have a chiropractic exam as soon as they are born. Therefore it is important to get your other children's spine checked if they have not been checked.

I hereby consent to a complete professional chiropractic examination. I understand that my personal information will be kept confidential in accordance with the Registered Health Practitioners Act and Privacy Act.

Signature: _____ Date: _____

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INFORMED CONSENT
To CHIROPRACTIC TREATMENT
At the Almonte Chiropractic Centre
Dr. Mark Herman / Dr Jaye Carlson

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment, and diagnostic x-rays. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

_____
Doctor's Initials

_____ _____
Parent / Legal Guardian Signature Name of Parent / Legal Guardian (please print)

_____ _____
Witness Signature Name of Witness (please print)