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**Oakville  
Chiropractic  
Centre**

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### **PEDIATRIC HISTORY FORM**

#### OUTLINE OF OFFICE PROCEDURES & POLICIES

*(If you have been involved in motor vehicle accident or this is a work place injury, please advise front desk staff to ensure you are indeed filling out the correct paperwork for your claim)*

**Step One:** Please ensure you have signed in at our office register this first visit, and each subsequent visit.

**Step Two:** All new patients will be asked to complete a personal health history regarding current and past health problems.

**Step Three:** You will have a consultation with a doctor to further discuss your health and wellness concerns.

**Step Four:** The doctor will complete neurological, orthopaedic, and chiropractic diagnostic testing specific to your condition.

**Step Five:** The doctor will advise you as to the need of additional procedures such as laboratory tests and x-rays, if necessary.

**Step Six:** If your case requires immediate attention, emergency care will be administered, or referrals made.

**Step Seven:** After history and exam procedures, you will be advised as to a time you may return to meet with the doctor for your 'Report of Findings' where the doctor will review pertinent findings regarding your case, as well as provide you with information regarding potential treatment options. It is at this visit you may discuss financial arrangements, insurance coverage, and other information as it applies to you.

#### **Child's Information**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Birth date: Day: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone #: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Email address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Sex (Please circle): M / F Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Name of Parents/Guardians: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

What is your purpose for contacting us? \_\_\_\_\_

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Has your child seen any other healthcare practitioners about this condition? Yes / No

Name of practitioner and prior treatments: \_\_\_\_\_

List any other health problems your child has experienced: \_\_\_\_\_

Check any of the following conditions your child has suffered from during the past six months:

- |   |   |                                      |   |  |
|---|---|--------------------------------------|---|--|
| <input type="checkbox"/> Ear Infections     | <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> Seizures    | <input type="checkbox"/> Chronic Cold     | <input type="checkbox"/> Headaches     |
| <input type="checkbox"/> Asthma / Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD        | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Back Pains         | <input type="checkbox"/> Temper Tantrums    | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Car Accident     | <input type="checkbox"/> Colic         |

Other: \_\_\_\_\_

List any known genetic/family illnesses or diseases? \_\_\_\_\_

If your child has seen a chiropractor prior to visiting our clinic, please confirm the below:

Date of last visit (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_

What is the name of your child's pediatrician:

Date of last visit (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_

Are you satisfied with the care your child has received there? Yes / No

What is the number of doses of antibiotics your child has taken:

- During the past six months? \_\_\_\_\_
- During his or her life time? \_\_\_\_\_
- I do not recall

What is the number of doses of other prescription medications your child has taken:

- During the past six months? \_\_\_\_\_
- During his or her life time? \_\_\_\_\_
- I do not recall

Vaccination History:

\_\_\_\_\_  
\_\_\_\_\_

### **Prenatal History:**

Name of Obstetrician / Midwife: \_\_\_\_\_

Did you experience complications during pregnancy? Yes / No

If yes, please list: \_\_\_\_\_

Did you have ultrasounds during your pregnancy? Yes / No If yes, how many? \_\_\_\_\_

Did you take any medications during pregnancy or delivery? Yes / No

If yes, please expand: \_\_\_\_\_

Did you consume alcohol or cigarettes during pregnancy? Yes / No

If yes, please expand: \_\_\_\_\_

Location of Birth:       Hospital       Birthing Centre       Home

Birth Intervention:       Forceps       Vacuum Extraction       C-section (emergency)       C-section (planned)

Did you experience complications during pregnancy? Yes / No

If yes, please expand: \_\_\_\_\_

Was your child born with any genetic disorders or disabilities? Yes / No

If yes, please expand: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_

#### Feeding History:

Breast Fed: Yes / No      How Long: \_\_\_\_\_

Formula Fed: Yes / No      How Long: \_\_\_\_\_

Introduced Solids at how many months? \_\_\_\_\_ Introduced Cows' Milk at how many months? \_\_\_\_\_

Does your child have any food/juice allergies or intolerances? Yes / No

If yes, please expand: \_\_\_\_\_

#### Developmental History:

During the following times your child's spine is the most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to do the following:

Respond to sound? \_\_\_\_\_ Respond to visual stimuli? \_\_\_\_\_ Cross crawl? \_\_\_\_\_

Stand alone? \_\_\_\_\_ Hold head up? \_\_\_\_\_ Walk alone? \_\_\_\_\_

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? Yes / No

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? Yes / No

If yes, please expand: \_\_\_\_\_

Has your child ever been involved in a car accident? Yes / No

If yes, please expand: \_\_\_\_\_

Has your child ever been seen on an emergency basis? Yes / No

If yes, please expand: \_\_\_\_\_

Has your child experienced any other traumas not described above? Yes / No

If yes, please expand: \_\_\_\_\_

Has your child had any surgical procedures? Yes / No

If yes, please expand: \_\_\_\_\_

Has your child started menstruating? Yes / No

If yes, please expand: \_\_\_\_\_

**Childhood Diseases:**

Please confirm the diseases from the list below that your child has had:

Chicken Pox: Y / N Age: \_\_\_\_\_ Mumps: Y / N Age: \_\_\_\_\_

Rubella: Y / N Age: \_\_\_\_\_ Whooping Cough: Y / N Age: \_\_\_\_\_

Rubeola: Y / N Age: \_\_\_\_\_ Other: Y / N Age: \_\_\_\_\_

**WE ARE HERE TO SERVE YOU, AND ENCOURANGE YOU TO ASK QUESTIONS.**

**YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.**

**AUTHORIZATION FOR CARE OF MINOR SEE NEXT PAGE:**



## Informed Consent

I hereby request and consent to the performance of Chiropractic Adjustments and adjunct procedures including but not limited to various modes of physical therapy, soft tissues and trigger point techniques, electromodalities, spinal decompression, and if deemed necessary diagnostic x-rays performed on me by the Chiropractors of Oakville Chiropractic Centre.

I understand I have an opportunity to discuss with the doctor and/or additional office personnel, the nature and purpose of my treatment. I understand that results cannot and are not guaranteed.

I further understand and am informed that, as with all health care, in the practice of Chiropractic there are some slight risks associated with treatment including but not limited to muscle strains, sprains, disc injury, and stroke. I do not expect the doctor to be able to anticipate all risks and complications; and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels, at the time, based on the facts then known, to be in my best interests.

I have read the above consent. I have had the opportunity to ask questions about this consent and by signing below agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I also give permission to Oakville Chiropractic to contact me via the email address which I have provided regarding appointments, promos, and any office news and events.

Date: \_\_\_\_\_

Patient Name (Please Print): \_\_\_\_\_

Patient Signature (Please Sign): \_\_\_\_\_

OCC Witness Name (Please Print): \_\_\_\_\_

OCC Witness Signature (Please Sign): \_\_\_\_\_

## Extended Health Information

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Member ID: \_\_\_\_\_

Coverage (*Please select all that apply*) Chiropractic \$ \_\_\_\_\_ Orthotics \$ \_\_\_\_\_ Massage \$ \_\_\_\_\_

