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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?_____

_____

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:

□ Ear Infections	□ **Scoliosis**	□ **Seizures**	□ **Chronic Cold**	□ **Headaches**
□ **Asthma / Allergies**	□ **Digestive Problems**	□ **ADHD**	□ **Recurring Fevers**	□ **Growing Pains**
□ **Back Pains**	□ **Temper Tantrums**	□ **Bed Wetting**	□ **Car Accident**	□ **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 lace 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 $ _____

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