Child Health Record

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better please complete the following information about your child. We look forward to working with you to build better health for your family.

Child's Name:				Parent's email:	
Address:				City:	Postal Code:
Telephone:		Number of siblings:		Date of birth(dd/mm/yyyy):	
Age:	Height:	Weight:	Sex: ☐M ☐F	Previous Chiropractor:	
Father's Name:				Contact #: home cell work	
Mother's Name:				Contact #: home cell work	

Purpose of this Visit

☐ Wellness Checkup ☐ Accident or Fall

☐ Illness or other health problem, Specify:_____

Have any other Doctors been consulted for this condition? ☐ Yes ☐ No

Please provide the Doctor's name and types of treatments:_____

_____

Prenatal History

Ultrasounds during pregnancy: ☐ Yes ☐ No How many:_____

Medications during pregnancy or labour/delivery? ☐ Yes ☐ No Please list:_____

Complications during pregnancy? ☐ Yes ☐ No

Please list:_____

Complications during labour/delivery? ☐ Yes ☐ No

Pulling/ twisting during birth (even mild)? ☐ Yes ☐ No

Location of birth: ☐Hospital ☐Birthing Centre ☐Home

Type of birth: ☐Vaginal ☐Forceps ☐Vacuum ☐Breech ☐Caesarean

Was an epidural given? ☐ Yes ☐ No

Was labour induced? ☐ Yes ☐ No Why?_____

Birth Weight:_____ Birth Length:_____ APGAR Scores:_____

Genetic disorders or disabilities? ☐ Yes ☐ No Please list:_____

Feeding History

Breast fed? ☐ Yes ☐ No How long?_____ Formula fed? ☐ Yes ☐ No How long_____

Food/juice allergies or intolerances? ☐ Yes ☐ No

Please list:_____

Introduced to solid foods at_____months, Cow's milk at _____months.

Does your child consume any foods containing: ☐Caffeine ☐Artificial Sweeteners

Developmental History

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

At what age was your child able to: Respond to sound: _____ Follow an object with eyes:_____

Hold head up: _____ Sit up: _____ Crawl:_____

Stand alone: _____ Walk alone: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of their life (i.e. bed, changing table, stairs etc.) Was this the case with your child?

☐ Yes ☐ No Please list:_____

Has your child ever been involved in any high impact or contact type of sports (i.e. soccer, football, gymnastics etc.) ☐ Yes ☐ No Please list:_____

Has your child ever been treated on an emergency basis: ☐ Yes ☐ No

Please describe:_____

Other injuries or falls not described above:_____

Childhood Diseases Has your child had any of the following illnesses?

☐ Measles ☐ Mumps ☐ Rubella

☐ Pertussis ☐ Chicken Pox ☐Other:_____

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

☐ Ear Infections	☐ Diarrhea	☐ Recurring Fevers	☐ Numbness/Tingling
☐ Asthma/Allergies	☐ Colic	☐ Car Accidents	☐ Digestive Problems
☐ Poor appetite	☐ Fatigue	☐ Dizziness	☐ Learning Disabilities
☐ Hyperactivity	☐ Headaches	☐ Stomach Aches	☐ Chronic Colds
☐ Bed Wetting	☐ Seizures	☐ Temper Tantrums	☐ Back/Neck "growing pains"
☐ Scoliosis	☐ Diabetes	☐ Constipation	☐ Sleeping Problems

☐ Other:_____

Number of doses of antibiotics your child has taken:

During Past 6 months:_____ During his/her lifetime:_____

Number of doses of other prescription medications your child has taken:

During the past 6 months:_____ During his/her lifetime:_____

Please list medications:_____

On a scale of 1-10 (10 being the highest), what is your commitment to improving your child's overall health?

1 2 3 4 5 6 7 8 9 10

Ancaster Family Chiropractic

397 Wilson St. E. Ancaster L9G 2C4 905.648.6530

Terms of Acceptance

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking about, and working towards the same goal. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal:

TO LOCATE, ANALYZE AND CORRECT SPINAL INTERFERENCE TO THE NERVOUS SYSTEM

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment or improper motion producing nerve interference), in and of itself, is a detriment to life and health. Correction of the SUBLUXATION through a specific chiropractic adjustment allows the body to function at its optimal level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain and promote health.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including diagnostic x-rays (if necessary) on me by the doctor and/or anyone working in this clinic authorized by the doctor.

I will have an opportunity to discuss with the doctor and/or staff, the nature and purpose of chiropractic adjustments and other procedures. I understand that the results expected are not guaranteed, as every person is unique.

I further understand and I am informed that, as in all health care, in the practice of chiropractic, there are some very slight and minimal risks to care, including, but not limited to: minor muscle strains and sprains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise professional judgment during the course of the procedure which the doctor feels at this time, based upon the facts then known, is in my best interest.

I have read the above consent. I will have an opportunity to ask questions about this consent, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of care for my present condition and for any future condition(s) for which I seek care in this office.

TO BE COMPLETED BY PATIENT

_____ _____

Print Name Signature of Patient (or parent/guardian)

_____ _____

Witness Date Signed

Ancaster Family Chiropractic
397 Wilson Street East
Ancaster, Ontario

X-RAY RELEASE FORM

This is to certify that Ancaster Family Chiropractic has permission to take x-rays if necessary.

Print Name: _____

Signature:_____ Date:_____

Witness: _____ Date: _____

Women Only

This is to certify, to the best of my knowledge, that I am **NOT** pregnant.

Signature:_____ Date:_____