Whom may we thank for referring you to our office? _____

NIVERVILLE FAMILY CHIROPRACTIC
102-106 Main St., Niverville, MB R0A 0A1
204.881.5555

PEDIATRIC HISTORY FORM

Today's Date: _____

Name_____ Date of Birth _____/_____/_____ MHSC # _____ Reg# _____
(As it appears on MHSC card) (day/month/year)

Address _____ City _____ Province _____ Postal Code_____

Phone (Home) _____ Mothers mobile: _____Fathers mobile: _____

Mother's Name_____ Father's Name _____

Pediatrician/Family MD _____City & Prov. _____ Last Visit: ____/____/____

Purpose of last visit _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ Age: _____

Ever been under chiropractic care? ☐ No ☐ Yes: Who/When? _____

PREGNANCY HISTORY:

Third Trimester Presentation: _____Vertex _____Breech _____Transverse _____Face/Brow

Type of Birth: _____Normal Vaginal _____Forceps _____Cesarean _____Suction Cap or Vacuum

Location: _____Home _____Hospital _____Birthing Center _____Other:_____

Problems during Pregnancy: _____

Problems during Labor/Delivery: _____

Was there presence of: _____Jaundice? (Yellow) _____Cyanosis? (Blue) _____Congenital Anomalies/Defects?

*If yes, please explain*_____

INFANT HISTORY:

Infant feeding: _____Breast _____Bottle If Bottle; which Formula? _____

Number of Hours sleep per night _____ Quality of Sleep: _____Good _____Fair _____Poor

List all **IMMUNIZATIONS** you child has had**:** _____

Has your child ever been treated at the emergency room? _____ If yes; please explain _____

Has your child ever been hospitalized? _____ If yes; please explain _____

Has your child ever had any Surgeries? _____ If yes; please explain _____

Is your child currently on any medication? _____ If yes; please list: _____

AT WHAT AGE DID THE CHILD:

Respond to sound_____ Follow an object with his/her eyes_____ Hold heel up_____
Sit Alone_____ Crawl_____ Stand_____ Walk alone_____

AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:

Chicken pox_____ Mumps_____ Measles_____ Rubella_____
Whooping Cough_____ Other: _____

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HAS YOUR CHILD EVER SUFFERED FROM:

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to_____
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Allergies to_____
☐ Asthma	☐ Scoliosis	☐ Anemia	☐ Allergies to_____
☐ Colds/Flu	☐ Walking Trouble	☐ Bed Wetting	☐ Other: _____
☐ Colic	☐ Broken Bones	☐ Sleeping Problems	☐ Other: _____

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall off skateboard or skates
☐ Fall from crib	☐ Fall off swing	☐ Fall off bicycle
☐ Fall from high chair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ Other: _____

Has your child ever sustained an injury playing organized sports? _____ If yes; please explain_____

_____

Has your child ever sustained an injury in an auto accident? _____ if yes; please explain_____

_____

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: *Write "C" for child, "F" for family member:*

____ Heart Disease	____ Diabetes	____ Stroke
____ Cancer	____ High / Low blood pressure	____ Asthma
____ Gastrointestinal disease	____ Memory/mood disorder	____ Thyroid problem

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness _____Check-up _____Other: _____

_____Pain/Discomfort; explain_____

_____Injury; explain_____

If due to Pain/Discomfort/Injury, please fill out:

1. **Onset** of Problem: Date ____/____/_____ _____Unknown _____Gradual _____Sudden
2. **Ever had** this problem **before**? ☐ No ☐ Yes If yes when? _____
3. Any **bowel or bladder** problems since this problem began?: No Yes *(Describe)*:_____
4. Any **medication taken** for this problem? No Yes: _____
5. Have you seen any **other doctors** for this problem? No Yes: _____
6. How is this problem **NOW:** ☐Rapidly Improving ☐Improving Slowly ☐About the Same ☐Gradually Worsening ☐On & Off

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Manitoba Chiropractors Association

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CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____
Patient Name

_____ _____ _____
Patient/Guardian Date Chiropractor

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