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

NIVERVILLE FAMILY CHIROPRACTIC

2 - 166 Main St., Niverville, MB R0A 1E0
204.388.6195

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: ____

Niverville
Family Chiropractic

HAS YOUR CHILD EVER SUFFERED FROM:

☐ Headaches
☐ Dizziness
☐ Fainting
☐ Seizures/Convulsions
☐ Heart Trouble
☐ Chronic Earaches
☐ Sinus Trouble
☐ Asthma
☐ Colds/Flu
☐ Colic

☐ Orthopedic Problems
☐ Neck Problems
☐ Arm Problems
☐ Leg Problems
☐ Joint Problems
☐ Backaches
☐ Poor Posture
☐ Scoliosis
☐ Walking Trouble
☐ Broken Bones

☐ Digestive Disorders
☐ Poor Appetite
☐ Stomach Aches
☐ Reflux
☐ Constipation
☐ Diarrhea
☐ Hypertension
☐ Anemia
☐ Bed Wetting
☐ Sleeping Problems

☐Behavioral Problems
☐ ADD/ADHD
☐ Ruptures/Hernia
☐ Muscle Pain
☐ Growing Pains
☐ Allergies to___________________
☐ Allergies to___________________
☐ Allergies to___________________
☐ Other: ______________________
☐ Other: ______________________

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

☐ Fall in baby walker
☐ Fall from crib
☐ Fall from high chair
☐ Fall from changing table

☐ Fall from bed or couch
☐ Fall off swing
☐ Fall off slide
☐ Fall off monkey bars

☐ Fall off skateboard or skates
☐ Fall off bicycle
☐ Fall down stairs
☐ 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
____ Cancer
____ Gastrointestinal disease

____ Diabetes
____ High / Low blood pressure
____ Memory/mood disorder

____ Stroke
____ Asthma
____ 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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Consent to Chiropractic Adjustments and Care

It is important for you to consider the benefits, risks and alternatives to the options provided to you by your Doctor of Chiropractic. This will allow you to make an informed decision as you begin your chiropractic care in the office.

Chiropractic care includes adjustments and mobilization of the spine and other joints of the body. It may also include soft tissue techniques such as massage, and exercise.

Benefits

Chiropractic adjustments have been demonstrated to be effective for complaints of the back and other areas of the body caused by stress to the nerves, muscles, joints and related tissues. Adjustments and care by your Doctor of Chiropractic can also relieve pain including headaches, altered sensation, muscle stiffness and spasms. It can also increase mobility, improve sleep, improve function of the body so that you have more energy, support the immune system, support hormonal balance and reduce or eliminate the need for drugs and surgery.

Risks

As with any form of treatment there are always risks associated with it. The risks associated with chiropractic care vary according to each person's condition, as well as the location and type of treatment. A proper health history and evaluation procedures are used in the office to minimize any risk. However, some underlying challenges cannot be anticipated and may lead to some of the following risks

- While *rare*, some people may experience a temporary worsening of conditions. Usually, any increase in pre-existing symptoms of pain or stiffness will only last a few hours to a few days.
- While *rare*, some people may experience a muscle or ligament strain or sprain as a result of manual adjusting techniques. Although uncommon, rib fractures have also been known to occur. This will usually resolve itself within a few days or weeks with some rest and care.
- Over the course of a lifetime, spinal discs may degenerate or become damaged with normal daily activities such as bending or lifting. People with degenerated or damaged discs may or may not have symptoms. X-rays are taken so that we may provide the best care based on the health of your spine. There are rare reported cases of disc injuries following cervical and lumbar adjustments, although *no scientific evidence* has demonstrated such injuries are caused, or may be caused, by spinal adjustments of other chiropractic care.

- There are reported cases of strokes associated with visits to medical doctors and Doctors of Chiropractic. Research and scientific evidence does not establish a cause and effect relationship between chiropractic care and the occurrence of a stroke. Recent studies show that this association occurs very infrequently and is explained by the fact that the artery was already damaged and the person was progressing toward a stroke when they consulted the chiropractor. A thorough history and examination is performed in the office to ensure the best care for you is provided.

Alternatives

In some cases, alternatives to chiropractic care may be recommended. As Doctors of Chiropractic we may collaborate and consult other health professionals so that you get the best outcome. You may also receive exercises with or without chiropractic adjustments depending on your individual situation.

Questions or Concerns

You are part of the healing process and we encourage you to ask questions at any time regarding your care in our office. Bring any concerns you may have to our attention. You also have the right to stop your care at any time.

Please be involved in and responsible for your health care.
Inform your chiropractor immediately of any changes in your condition.

DO NOT SIGN UNTIL YOU HAVE MET WITH YOUR CHIROPRACTOR AND DISCUSSED YOUR CARE

I hereby acknowledge that I have read this consent and I have had the opportunity to discuss with the chiropractor the nature and purpose of chiropractic care in general as well as the care options and recommendations for me. I have considered the benefits and risks of chiropractic care, as well as the alternatives. I hereby consent to chiropractic care recommended to me.

____
Name (Please Print)

______________________________ Date______________20______
Signature of Patient (or legal guardian)

______________________________ Date______________20______
Signature of Chiropractor