



## Paediatric Pre-Exam Information

(Birth-2yrs)

Name \_\_\_\_\_ Date of Birth \_\_\_\_ DD \_\_\_\_ MM \_\_\_\_ YY

Gender \_\_\_\_\_ Sex ☐ M ☐ F

Address \_\_\_\_\_ Postal Code \_\_\_\_\_

City/Township \_\_\_\_\_

Email \_\_\_\_\_

Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Siblings Names \_\_\_\_\_ Age \_\_\_\_\_

\_\_\_\_\_ Age \_\_\_\_\_

\_\_\_\_\_ Age \_\_\_\_\_

Family Physician \_\_\_\_\_ Paediatrician \_\_\_\_\_

Obstetrician \_\_\_\_\_ Midwife \_\_\_\_\_

### Current Health Concerns

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List other care undergone for this complaint (including medications)

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### Other Health Concerns

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Were you referred to this office? Yes/No By Whom? \_\_\_\_\_  
(ie: friend, family member, doctor)

## Pregnancy

Please check any areas that applied to the patient's mother during her pregnancy

- |  |  |
|--|--|
| <input type="checkbox"/> Medications             | <input type="checkbox"/> Premature Contractions        |
| <input type="checkbox"/> Complications           | <input type="checkbox"/> Back pain                     |
| <input type="checkbox"/> Smoking                 | <input type="checkbox"/> Excessive weight loss or gain |
| <input type="checkbox"/> Alcohol                 | <input type="checkbox"/> Allergic reactions            |
| <input type="checkbox"/> Vitamins/Minerals       | <input type="checkbox"/> Physical Injury               |
| <input type="checkbox"/> Any diagnosed illnesses | <input type="checkbox"/> Prenatal classes              |
| <input type="checkbox"/> Hospitalizations        | <input type="checkbox"/> Chiropractic care             |
| <input type="checkbox"/> Bleeding                | <input type="checkbox"/> Mental Trauma                 |

## Labour and Delivery

- |  |  |
|--|--|
| <input type="checkbox"/> Greater than 12 hours | <input type="checkbox"/> Complications     |
| <input type="checkbox"/> Fetal monitor used    | <input type="checkbox"/> Medications       |
| <input type="checkbox"/> Forceps               | <input type="checkbox"/> Caesarian         |
| <input type="checkbox"/> Hospital              | <input type="checkbox"/> Home birth        |
| <input type="checkbox"/> Breech                | <input type="checkbox"/> Vacuum extraction |
| <input type="checkbox"/> Other                 |  |

## Prenatal History

If known, please indicate:

The duration of the pregnancy was \_\_\_\_\_ weeks.

The APGAR score at birth \_\_\_\_\_ and at five minutes \_\_\_\_\_.

The birth weight was \_\_\_\_\_.

Any problems at birth with:    ☐ Jaundice (yellow)    ☐ Nursing    ☐ Sleeping

## Nutrition

Please check if the patient has received any of the following items:

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Breast milk        | <input type="checkbox"/> Solid foods |
| <input type="checkbox"/> Cow's milk         | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Other milk         | <input type="checkbox"/> Vitamins    |
| <input type="checkbox"/> Commercial formula |                                      |

**For Babies under 6 months old, please circle either AGREE or DISAGREE for each statement:**

- (A). Your baby does not calm down or fall asleep during a car ride. AGREE/DISAGREE
- (B). Your baby does not calm down or fall asleep when held against your chest or cradled in the crook of your arm, while you are walking around at a brisk pace. AGREE/DISAGREE
- (C). When your baby has fallen asleep against your chest you cannot lay the baby supine (on their back) in the crib without the baby waking up and crying. AGREE/DISAGREE
- (D). When sleeping the baby may wake up with a scream, showing the symptoms of the Moro reflex. AGREE/DISAGREE
- (E). The baby is much more comfortable lying inclined in a car seat than supine (on their back) in a crib. AGREE/DISAGREE

## Health History

Please check any of the following that apply to the child.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Asthma         |
| <input type="checkbox"/> Mumps           | <input type="checkbox"/> Backaches            | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Chicken pox     | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Scoliosis      |
| <input type="checkbox"/> Colic           | <input type="checkbox"/> Digestive problems   | <input type="checkbox"/> Growing pains  |
| <input type="checkbox"/> Ear infections  | <input type="checkbox"/> Hyperactivity        | <input type="checkbox"/> Allergies      |
| <input type="checkbox"/> Bedwetting      | <input type="checkbox"/> Walking difficulties | <input type="checkbox"/> Broken bones   |
| <input type="checkbox"/> Constipation    | <input type="checkbox"/> Poor appetite        | <input type="checkbox"/> Anemia         |
| <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Convulsions    |
| <input type="checkbox"/> Other – Explain |   |   |

## Family Medical History

Please check if any blood relatives to the patient has had any of the following illnesses by noting:

**M** (mother) **F** (Father) **S** (Siblings) **PGM** (paternal grandmother) **MGM** (maternal grandmother)

**PGF** (paternal grandfather) **MGF** (maternal grandfather)

- |   |                      |                     |
|---|----------------------|---------------------|
| _____ Allergies   | _____ Liver disease  | _____ Asthma        |
| _____ Mental Illness  | _____ Cancer         | _____ Scoliosis     |
| _____ Diabetes  | _____ Ulcer          | _____ Heart trouble |
| _____ High blood pressure/stroke  | _____ Kidney disease |                     |
| _____ Autoimmune disease (ie, Lupus, Rheumatoid Arthritis, Celiac disease, crohn's disease) |                      |                     |

### Consent to Chiropractic Treatment

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft tissue techniques such as massage, and other forms of therapy including but not limited to, electrical or light therapy and exercise.

#### Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

#### Risks

The risk associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

- **Temporary worsening of symptoms**-Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days
- **Skin irritation or burn**-Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quick. A burn may leave a permanent scar.
- **Sprain or strain**-Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture**-While rib fracture is painful and can limit your activity for a period of time; it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc**-Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravation of a pre-existing disc condition will vary with each patient. In the most severe cases, patients symptom may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke**-Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through adding of disease, or as a result of injury. A blood clot may form in a damaged artery. All part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke. Common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the , or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted a chiropractor. Present medical and scientific evidence does not establish that a chiropractic treatment causes either damage to an artery or stroke.

**Alternatives**-Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

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

**Do NOT sign this form until you meet with the chiropractor**

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

\_\_\_\_\_  
Name (Please print)

\_\_\_\_\_  
Signature of Patient (or legal guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Chiropractor

\_\_\_\_\_  
Date

