Paediatric Pre-Exam Information

(2yrs-10yrs)

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_____

Current Health Concerns

_____
_____
_____

List other care undergone for this complaint (including medications)

_____
_____

Other Health Concerns

_____
_____

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

Did your child have any of these challenges as an infant?

Difficulty with breastfeeding/latch	□ YES	□ NO
Tongue Tie	□ YES	□ NO
Colic	□ YES	□ NO
Torticollis	□ YES	□ NO
Positional head deformity	□ YES	□ NO
Reflux	□ YES	□ NO

Provide dates of **ALL** surgeries, fractures, major illnesses, falls or injuries:

_____

_____

List **ALL** motor vehicle accident dates (Please Describe):

_____

_____

Check √ any conditions which are **presently** causing you a problem. Please underline conditions which **were** a problem in the past.

GENERAL
- ☐ headache
- ☐ migraines
- ☐ dizziness
- ☐ ringing in ears
- ☐ fainting
- ☐ earache
- ☐ sore throat
- ☐ nose bleeds
- ☐ sinus problems
- ☐ asthma
- ☐ enlarged glands
- ☐ unexplained weight loss
- ☐ hypoglycemia
- ☐ nervousness/anxiety
- ☐ depression/confusion`
- ☐ vision problems
- ☐ dental problems
- ☐ hearing problems
- ☐ fever
- ☐ night sweats

ORGANS
- ☐ frequent urination
- ☐ painful urination
- ☐ blood in urine
- ☐ bladder problems
- ☐ bed wetting
- ☐ anemia
- ☐ eating disorders
- ☐ thyroid problems
- ☐ excessive appetite
- ☐ gas/ bloating
- ☐ nausea/vomiting
- ☐ constipation/diarrhea
- ☐ black/ bloody stool
- ☐ rheumatic fever `

SKIN
- ☐ eczema
- ☐ skin eruptions
- ☐ rashes
- ☐ loss of sensation

RESPIRATORY & HEART
- ☐ lung problems
- ☐ frequent colds/flu
- ☐ difficulty breathing
- ☐ heart problems

MUSCLE & JOINT
- ☐ neck problems
- ☐ whiplash
- ☐ upper back problems
- ☐ low back problems
- ☐ tailbone pain
- ☐ spinal curvature
- ☐ pelvic numbness/or pins and needles
- ☐ limb problems
- ☐ walking problems
- ☐ sore joints
- ☐ jaw problems

Do any health concerns/diseases run in the family?

_____

_____

LIFESTYLE:

	None	Light	Moderate	Heavy
Exercise	☐	☐	☐	☐
Pop	☐	☐	☐	☐
Junk Food	☐	☐	☐	☐

Please rate your child's sleep, hours per night ☐ 4 - 6 hrs ☐ 6 – 8 hrs ☐ 8 – 10 hrs ☐ 10hrs+

Healthy Families
WELLNESS CENTRE

Informed Consent to Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

A) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscles and ligaments strains or sprains following spinal adjustments.

B) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of the possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.

C) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic is substantially lower than that associated with many medical or other treatments, medication, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this consent.

Dated this _____day of _____, 20 _____

Patient Signature (Legal Guardian) Name (Please print)

Witness of Signature Name (Please print)