

Child History Form

Please complete the following as completely as possible. If you need assistance, please ask the front desk staff and they will be glad to assist you.

Child's Name: _____ Date: _____

Parent(s) Name: _____

Sibling(s) Name(s) (Ages): _____

Address: _____ City: _____ Prov. _____

Postal Code: _____ Home Phone: (____) _____ Bus Phone: (____) _____

Date of Birth: _____ Age: ____ Gender: M F Referred by: _____

Has your child ever received chiropractic care? Yes No If yes, previous DC's name and last visit date?

Name of Medical Doctor: _____

Date of last MD visit and reason: _____

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

PARENT(S) NAME(S): _____ WORK TEL: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____

Present Health Complaints/Concerns:

Major: _____

Minor: _____

When did this problem begin? _____

Is this problem: Occasional Frequent Constant Intermittent

Does problem radiate? Yes No If yes, where? _____

What makes this worse? _____

What makes this better? _____

Is the problem worse during a certain time of the day? Yes No If yes, when? _____

Does this interfere with the child's Sleep? Eating? Daily Routine?

Is this becoming worse? _____

Other professionals seen for this condition? _____

Results with that treatment? _____

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS: (please check if your child has had any of the following)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss Of Taste | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Upper Back Pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Fevers | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Radiating Pain |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Chest Pressure | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Breast Pain | <input type="checkbox"/> Reduced Mobility |
| <input type="checkbox"/> Loss Of Balance | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Numbness In Leg(s) |
| <input type="checkbox"/> Loss Of Concentration | <input type="checkbox"/> Shortness Of Breath | <input type="checkbox"/> Sinus Congestion | <input type="checkbox"/> Numbness In Feet |
| <input type="checkbox"/> Loss Of Memory | <input type="checkbox"/> Asthma | <input type="checkbox"/> Sore Throats | <input type="checkbox"/> Numbness In Hand(s) |
| <input type="checkbox"/> Ears Buzzing | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Ear Pain / Infections | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Poor Coordination | <input type="checkbox"/> Constipation | <input type="checkbox"/> Allergies | <input type="checkbox"/> Muscle Cramps |
| <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Loss Of Smell | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Bloating / Gas | |
| <input type="checkbox"/> Other: _____ | | | |

History of Birth

What was the child's gestational age at birth? _____ Weeks.

Birth weight _____ lbs. _____ oz. Birth length _____ inches

Was your child's birth at home in a birthing center in a hospital

Was the birth considered medical midwife

What was the duration of the labour and birth? _____ hours

Was child born Cephalic (head first) Breech (feet first)

Were there any complications? Yes No If yes, please explain _____

Please check any assistance which was used during the birth:

- Forceps Vacuum Extraction C-Section Episiotomy

Was labour Spontaneous Induced

Were medications or epidurals given to the mother during birth? Yes No If yes, what was given? _____

APGAR score: at Birth _____/10 After 5 minutes _____/10

Growth and Development

Was the infant alert and responsive within 12 hours of delivery? Yes No If no, please explain _____

At what age did the child: Respond to sound _____ Follow an object _____ Hold up head _____ Vocalize _____
Sit alone _____ Teeth _____ Crawl _____ Walk _____

Do you consider the child's sleeping pattern normal? Yes No If no, please explain _____

Family Health History

Please note any health problems (Eg. Cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:

Mother's family _____

Father's family _____

Sibling(s) _____

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Physical Stressors

Any traumas to the mother during pregnancy? (Eg. Falls, accidents, etc.) Yes No If yes, please explain _____

Any evidence of birth trauma to the infant?

- | | | |
|---|---|---|
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Odd Shaped Head | <input type="checkbox"/> Stuck In Birth Canal |
| <input type="checkbox"/> Fast Or Excessively Long Birth | <input type="checkbox"/> Respiratory Depression | <input type="checkbox"/> Cord Around Neck |

Any falls from couches, beds, change tables, etc? Yes No If yes, please explain _____

Any traumas resulting in bruises, cuts, stitches, or fractures? Yes No If yes, please explain _____

Any hospitalizations or surgeries? Yes No If yes, please explain _____

Any sports played? _____

Is a school backpack used? Yes No If yes, is it Heavy Light

Chemical Stressors

Was this child breast-fed? Yes No If yes, how long? _____

Formula introduced at what age? _____ What formula? _____

Introduction of cow's milk at what age? _____

Began solid foods at what age? _____ Type of foods? _____

Food / Juice intolerance? Yes No If yes, what type? _____

During pregnancy, did the mother, smoke? Yes No How much? _____

drink? Yes No How much? _____

Any illnesses during the pregnancy? Yes No If yes, what illnesses? _____

Any supplements taken during pregnancy? Yes No If yes, what supplements? _____

Any drugs taken during pregnancy? Yes No If yes, what drugs? _____

Any ultrasounds? Yes No How many and reasons for being done? _____

Any invasive procedures during pregnancy (Eg. Amniocentesis, CVS, etc.)? Yes No Please explain _____

Any pets at home? Yes No If yes, what kind(s)? _____

Any smokers in the home? Yes No

Vaccination History

Vaccinations and age given? _____

Any negative reactions? Yes No If yes, what were they? _____

Any antibiotics given? Yes No Reason? _____

Psychosocial Stressors

Any difficulties with lactation? Yes No If yes, what are they? _____

Any problems with bonding? Yes No If yes, what are they? _____

Any behavioural problems? Yes No If yes, what are they? _____

Any night terrors sleep walking difficulty sleeping

Age of child when he/she began daycare? _____

Average number of hours of television per week? _____

Do you feel that your child's social and emotional development is normal for their age? Yes No If yes, how? _____

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

1. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments;
2. There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote;
3. There have been 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 multi-disciplinary studies conducted over many years and has been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, 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.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Date: _____

Print Clients' Name: _____

Client's or Guardian's Signature: _____

Witness of Signature: _____

EXTENDED HEALTH BENEFITS

CHECK-OFF LIST

Name _____

Date _____

We have prepared this list for you to help you get ALL the information you need when you call for your work Extended Health Benefits. We have included questions for all of the services we offer in our office. Dr. Cranton is licensed as both a Chiropractor and a Naturopathic Doctor, performs acupuncture, and is certified to cast and order custom orthotics.

Do you have Extended Health Benefits through your work or school? Yes No

Does your spouse, mother or father have Extended Health Benefits though his/her work?

Yes No (you are done with this form)

INFORMATION TO RECORD BEFORE YOU CALL:

Your work Insurance Company - Name: _____ Phone #: _____

Employer: _____

Employee: _____

Employee ID#: _____

Group policy #: _____

INFORMATION TO GET WHEN YOU CALL:

Is there a deductible? Yes - How much? \$ _____ No

Is this a family plan? Yes No

Is your limit: per calendar year per fiscal year _____ to _____ per 12 consecutive months

DO YOU HAVE CHIROPRACTIC COVERAGE? Yes No

What is your limit per year? \$ _____

What is your limit per visit? \$ _____

Do you have x-ray coverage? Yes No - Is it included in your maximum? Yes No

DO YOU HAVE NATUROPATHIC COVERAGE? Yes No

What is your limit per year? \$ _____

Is there a maximum per visit? \$ _____

Are there a maximum number of visits? No Yes _____

Are supplements covered if prescribed by a Naturopath? No Yes - maximum \$ _____

DO YOU HAVE ACUPUNCTURE COVERAGE? Yes No

What is your limit per year? \$ _____

What is your limit per visit? \$ _____

Are there a maximum number of visits? No Yes _____

DO YOU HAVE PRIVATE LAB COVERAGE? Yes No

Are private labs covered? (E.g. hair analysis, blood or urine or allergy tests) No Yes - maximum \$ _____

OTHER ITEMS TO CHECK ON:

Do they cover orthopedic cervical pillows? Yes No

Do you have coverage for COMPRESSION HOSIERY OR STOCKINGS? Yes No

What is your limit per year? \$ _____

Do you have CUSTOM ORTHOTICS coverage?

What is your limit per year \$ _____

How many pairs can you order? _____

Do you need a referral Chiropractor M.D. No

Do you get one pair per year or every second year?

CRANTON WELLNESS CENTRE

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