Justine Blainey Wellness Centre

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GUEST				

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Dr._____

Child and Pediatric Health 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

Who may we thank for referring you? _____

Has your child ever received chiropractic care? ☐ Yes ☐ No Chiropractor's Name:_____

Why This Form Is Important:

In this office, our focus is on helping people to function optimally so that they are stronger, healthier and better able to adapt to the stresses of everyday life. This form gives us a better understanding of the physical, chemical and emotional stresses that can gradually accumulate over time to produce health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

Physicians, Chiropractors, Osteopaths, and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or strokes like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Tests, with or without x-rays, have been performed on you to minimize this risk to yourself. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions. If you have any questions or concerns please speak to your doctor.

I understand all accounts are payable when service is rendered.

Consent to all encompassing Chiropractic treatments knowing the Doctor (s) will discuss ahead of time them with me. (Example: Orthotics, change of technique etc.)

Consent to seeing another JBWC Doctor if/when need. (Example: Time restrictions, scheduling, acute condition needing help and my primary Doctor is away etc.)

I understand that to provide me with health goods and services, the Justine Blainey Wellness Centre will collect some personal information about my child (e.g., home telephone number, address).

I understand that the Justine Blainey Wellness Centre has a Privacy Policy about the collection, use and disclosure of personal information, and steps taken to protect the information and my right to review my personal information.

I agree to the Justine Blainey Wellness Centre collecting, using, and disclosing personal information about me as set above and in the Justine Blainey Wellness Centre's Privacy Policy

I hereby authorize the release of my medical/chiropractic records or copies of the same to such parties that the doctor may deem necessary as it relates to my child's case, and do hereby hold harmless anyone from such actions.

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: _____

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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_____

_____

*If your child has no symptoms or complaints, and are here for wellness services, please check (√) here _____ and skip to "**Family Health Profile**"*

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?_____

_____

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

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

☐ Other: _____

Family Health History

Please note any health issues with family relations:

Brothers: _____

Sisters: _____

Father: _____

Mother: _____

Grandparents: _____

In this office we will perform a thorough assessment of your child's spine to locate areas of **Vertebral Subluxation**. Subluxations are the areas of dysfunction in the spine that interfere with the healthy connection between the nervous system and all the different parts of your body. This will result in compromised health and reduced energy to the tissue which that part of the nervous system supplies. Subluxations are caused by *physical, chemical* and *mental/emotional* stresses that overwhelm the nervous system and spine. Please complete this form to the best of your ability. This will help us to determine the causes of the subluxations we may find.

Physical Stressors

Any significant falls or trauma to the mother during pregnancy? ☐ Yes ☐ No ☐ Unsure

Any evidence of birth trauma to the infant?

☐ Bruising	☐ Odd Shaped Head	☐ Stuck In Birth Canal
☐ Fast or Excessively Long Birth	☐ Respiratory Depression	☐ Cord around Neck

For the child, were there any falls from couches, beds, change tables, etc? ☐ Yes ☐ No ☐ Unsure

Any hospital visits for concussions, possible fractures or other traumas? ☐ Yes ☐ No ☐ Unsure

Have there been any surgeries? ☐ Yes ☐ No

If yes, please explain: _____

Is a backpack worn? ☐ Yes ☐ No If yes, is it ☐ heavy or ☐ light?

Does your child participate in sports? ☐ Yes ☐ No _____

Any hobbies or activities which require prolonged, awkward or repetitive postures? (i.e. violin, gymnastics, etc.)

☐ Yes ☐ No ☐ Unsure

Sport History Injuries: Year: _____ Injury: _____

Year: _____ Injury: _____

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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

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.