Stibbard Chiropractic
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Pediatric Information Form (Birth-12 Years)

Name: _____ DOB: _____
Gender: Male Female Other: _____

Address: _____
City:_____ Province: _____
Home Phone: _____ Cell Phone: _____
Email: _____

Emergency Contact Name: _____
Phone Number: _____ Relationship: _____

Medical Dr. Name:_____Date of last physical: _____
Previous Chiropractor Name: _____
Permission to Contact above health care providers: Yes No

How did you hear about our clinic?: _____

Private Insurance Provider: _____
Policy #: _____ Member #: _____
Name of card holder: _____
Relationship to card holder: _____

Is this a workplace injury or motor vehicle accident?: _____
Claim Number: _____

Patient Information

Name: _____ Date:_____

Date of Birth: _____Age: _____Sex: □ Male □ Female

Parent(s) Name: _____

What is the primary reason that you are seeking Chiropractic care for your child?

_____

When did this problem begin?_____

Is it getting worse? □ Yes □ No

Is this problem:(circle) 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?____

Prenatal History

Any complications during pregnancy: _____

During pregnancy, did the mother:

Drink alcohol: □ Yes □ No

Use tobacco: □ Yes □ No

Vaccines/medications □ Yes □ No

Reasons for vaccines/medications: _____

Illnesses/infections during pregnancy: _____

Supplements during pregnancy: _____

Ultrasounds or other testing: _____

Birth History

Place of birth: □ Home □ Birthing Center □ Hospital

Provider: □ Midwife □ OB-Gyn □ Other

Type of Birth: □ Vaginal □ Cesarean

Duration of gestation:_____

Were pain medications used?_____

Was labour induced?_____

Birth trauma? □ Doctor Assisted □ Twisting/Pulling □ Vacuum Extraction □ Forceps

APGAR score if known?_____

Did your child have a misshaped skull/head? □ Yes □ No

Did your child have any bruising in the skull/face? □ Yes □ No Where? _____

Has your baby been diagnosed with any heart issues or other medical concerns? _____

Please list all medial diagnosis/ concerns: _____

Did you baby receive a Vitamin K injection at birth? □ Yes □ No

Vitamin K is routinely given to newborns unless you actively refused the treatment

Has your baby previously had a tongue or lip tie release? □ Yes □ No

Have you worked with a lactation consultant outside of the hospital? □ Yes □ No

<u>Growth and Development</u>

Was your infant alert and responsive within twelve hours of delivery? □ Yes □ No

At what age did your child:

Respond to sound: _____Hold up head:_____Begin to teethe: _____Crawl: _____

Follow an object: _____ Vocalize:_____ Sit up unassisted: _____Walk:_____

Has baby had a strong neck since birth? □ Yes □ No

Was baby able to roll to the side in the first weeks of life? □ Yes □ No

Is baby always turning their head to one side? □ Yes □ No L or R (please circle)

Does baby's body seem very tense or rigid □ Yes □ No

<u>Chemical Stressors</u>

Did you breast feed your child? □ Yes □ No How long?_____

Was formula introduced? □ Yes □ No At what age?_____

Began solids at what age? _____Type of first food?_____

List any food allergies?_____

Has your child been vaccinated? □ Yes □ No

Did your child have any reactions to these vaccines? □ Yes □ No

Has your child been on antibiotics? □ Yes □ No

If yes, how often and for what purpose?_____

Is your child currently taking any vitamins? □ Yes □ No

If yes, please list:_____

Please list all medication: _____

Please list any allergies if known:_____

How many glasses does your child drink per day? Water _____Milk _____Juice _____Soda

Does your child consume artificial sweeteners? □ Yes □ No

Rate your child's diet: □ Well-balanced □ Average □ High sugar/processed food

What is your child's favourite food? _____

Health History: Please fill out if age 0-4 years

Have any of the following occurred? Please circle

Jaundice	Anemia	Cyanosis	Seizures
Infections	Tonsilitis	Reflux	Repeated colds
Frequent ear infections	Colic	Frequent diarrhea	Constipation
Sleeping problems	Frequent fevers	Frequent crying spells	
Fall from a changing table	Fall out of crib	Fall off playground	Car accident
Tumble down stairs	Play in jolly jumper	Other: _____	

Health History: Please fill out if age 5-12 years

Have any of the following occurred? Please circle

Fall from a tree	Stomach pains	Bed-wetting	
Fall off a bicycle	Hyperactivity/Autism	Headaches/ migraines	
Fall on playground	Leg/Knee pains	Allergies	
Sports accident	Scoliosis	Growing pains	
Car accident	Learning difficulties	Asthma	Other:_____

Does your child participate in any athletic or extracurricular activities? □ Yes □ No

If yes, which ones?_____

How many hours of sleep does your child get per day?_____

Sleep quality: □ Good □ Fair □ Poor

Is there anything else the Doctor should know? _____

Have you, the child's legal guardian, had any personal experience with Chiropractic? □ Yes □ No

Authorization to Evaluate and Care for a Minor

I, _____, the undersigning parent/guardian having legal custody/guardianship of , a minor, do hereby authorize, request, and direct the staff and doctors of Stibbard Chiropractic Clinic to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Child's Name:_____

Parent/Guardian's Signature: _____Date: _____

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

● **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 quickly. A burn may leave a permanent scar.

● **Sprainorstrain** –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 a 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 may not know they have a problem with a disc. 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 aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms 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 aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or 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.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, 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 the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

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.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

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

I hereby acknowledge that I have read this form and discussed with the chiropractor the assessment of my condition and the 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.

Today's Date:_____

_____ _____

Patient Name (Please Print) Witness Name

_____ _____

Patient Signature (or Legal Guardian) Witness Signature