Goderich Chiropractic
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Pediatric History Form

(For Children 12 years and Under)

The purpose of our office is to restore and maintain the health of our patients through natural, chiropractic methods. Please complete this confidential Pediatric History Form fully and accurately. The more we know about the overall picture of your child's health the better we will be able to help you. If you have any questions, please don't hesitate to ask one of our chiropractic assistants for guidance.

Patient Information

Patient Full Name: _________________________________ Preferred First Name: ______________________________

Birth Date: __________________________ Gender: Male ☐ Female ☐ Height: ___________ Weight: _________

Parent/Guardian Information

Parent/Guardian Names: 1. ________________________________ 2. _______________________________________

Address: ____ City: _________________ Postal: _____________

Home Phone: ____________________ Cell Phone: ___________________ Work Phone: _______________

E-mail: _____________________________________

Who referred you to this office: ______________________________________

Emergency Contact: ______________________________________ Phone: ________________________

Patient Medical Information

Purpose for Visiting Us: ____

Have other doctors been seen for this condition? ☐ Yes ☐ No

If yes, list the doctors name(s) and treatments: ____

____

Check any of the following conditions your child has experienced during the past 6 months:

☐ADD / ADHD ☐ Allergies ☐ Asthma ☐ Autism

☐ Back Pain ☐ Bed Wetting ☐ Cancer ☐ Car Accident

☐ Chronic Colds ☐ Colic ☐ Diabetes ☐ Digestive Problems

☐ Ear Infections ☐ Epilepsy/Seizures ☐ Fainting Spells ☐ Growing Pains

☐ Headaches ☐ Neurological Disorders ☐ Recurring Fevers ☐ Scoliosis

☐ Temper Tantrums ☐ Thyroid Problems

Other Medical Conditions: ____

____

Family History: ____

Has the patient ever been adjusted by another Chiropractor? ☐ Yes ☐ No

Chiropractor's Name: ____

Reason(s) for those visits: ____

____

Were X-Rays taken? ☐ Yes ☐ No

Approximate date of last visit: _______________________________

Where you satisfied with the care your child has received there? ☐ Yes ☐ No

Name of Pediatrician/Family Doctor: __________________________________ Date of Last Visit: _____________________

Where you satisfied with the care your child has received there? ☐ Yes ☐ No

Number of Antibiotic prescriptions your child has been given in the past 6 months: ___________ Lifetime: ______________

Medications currently taking: ____

List other medications taken in the past 6 months w/ dosages: ____

____

Vaccinations: ____

Prenatal History

Name of Doctor /Midwife: ____

Complications During Pregnancy: ☐ Yes ☐ No List: ____

Ultrasounds During Pregnancy: ☐ Yes ☐ No How many: ________

Medications During Pregnancy/Delivery: ☐ Yes ☐ No List: ____

Cigarette / Alcohol Use During Pregnancy: ☐ Yes ☐ No Amount/Frequency: _________________________________

Location of Birth: ☐Hospital ☐ Birthing Centre ☐ Home Other: ______________________________________

Birth Intervention: ☐Forceps ☐ Vacuum Extraction ☐ C-Section If C-Section: ☐Emergency or ☐Planned

Complications During Delivery: ☐Yes ☐ No List: ____

Genetic Disorders or Disabilities: ☐Yes ☐ No List: ____

Birth Weight: ____________________ Birth Length: ____________________ Apgar Scores: _________________

Feeding History

Breast Fed: ☐Yes ☐ No How Long: _____________________________
Formula Fed: ☐Yes ☐ No How Long: _____________________________
Introduced Solids at: _____ months Introduced Cows Milk at _____ months
Food/Juice Allergies or Sensitivities ☐Yes ☐ No List: ____

Development History

During the following developmental stages, your child's spine is most vulnerable to stresses and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

At what age was your child able to:

Respond to sound: ___________ Respond to Visual Stimuli: _____________ Hold head up: ______________

Sit Up: ________ Crawl: _________ Stand on their own: ___________ Walk on their own: __________

Has your child ever had a head first fall: ☐Yes ☐ No

Is/Has your child been involved in any high impact or contact sport (e.g. Soccer, Football, Hockey, Gymnastics, Baseball, Cheerleading, Martial Arts, Ringette etc.)? ☐Yes ☐ No List: ____

Has your child been involved in a car accident: ☐Yes ☐ No List: ____

Has your child ever been seen on an emergency basis: ☐Yes ☐ No List: ____

Prior Surgeries: ☐Yes ☐ No List: ____

Describe any other traumas not listed above: ____

Childhood Diseases (Please mark all that apply)

☐Chicken Pox Age: _____ ☐Mumps Age: ____ ☐Rubella Age: _____ ☐Whooping Cough Age: ____

We are here to serve you and encourage you to ask questions. Your participation is vital and will help determine your child's results.

Authorization for Care for a Minor

I hereby authorize Goderich Chiropractic, it's doctors and staff to examine my child's conditions and administer care to my child as they deem necessary.

I clearly understand and agree that I am personally responsible for payment of all fees at the time services are rendered. I understand that if I suspend or terminate my child's care for any reason, any fees for professional services rendered will become immediately due and payable by me.

Name of Parent/Guardian: ____

Signature of Parent/Guardian: ____ **Date**: ________________________

Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgement during the procedure which the doctor feels at the time, based upon the facts then known, it is in my best interest.

I understand that from time to time Dr. Denunzio may be away for seminars and training. In that event, a locum doctor will be attending to my care and I hereby consent to care by that doctor.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment.

(Check if applicable) I have health insurance coverage and/or accident insurance ☐ through:

____

I understand that health and accident insurance policies are an arrangement between and insurance carrier and myself.

Print Patient's Name: ____

Signature of Patient (or parent/guardian) ___________________________________ **Date**: _____________________

Witness to Signature above: ____

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