

Children's Health Record

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About the Child

Name: _____

Address: _____

City: _____ Prov: _____ PC: _____

Birthdate: _____ yy/mm/dd

Age: _____ ☐ M ☐ F

Name of Parent: _____

Home Phone: _____

Parent's Work Phone: _____

Parent's Cell Phone: _____

Parent's Employer: _____

Mother's Pregnancy & Labour

During pregnancy, did mother: Yes No

Take any medication? ☐ ☐

Please explain: _____

Smoke or consume alcohol? ☐ ☐

Experience any illness? ☐ ☐

Please explain: _____

Approximately how long did labour last? _____ hours

Was labour chemically induced? ☐ ☐

Was labour doctor assisted? ☐ ☐

Was a C-Section performed? ☐ ☐

Were forceps or vacuum extraction used? ☐ ☐

Did the doctor pull or twist the baby during delivery? ☐ ☐

Was the delivery premature? ☐ ☐

If yes at _____ months and _____ weight

Please check any of the following if the child experienced it immediately after birth:

- ☐ Jaundice ☐ Respiratory problems
☐ Feeding problems ☐ Displaced or broken joints
☐ Other condition(s)

Please explain: _____

Please provide your email address to receive the following:

☐ Newsletters ☐ Reminders ☐ Birthday Present ☐ All

Email address: _____

(please print clearly)

Preferred method of contact:

☐ Home Phone ☐ Work Phone ☐ Cell Phone

☐ Email

☐ No phone calls ☐ No contact at all please

Reason For This Visit

Describe the purpose of this visit _____

Is the purpose of this appointment related to:

☐ Sports ☐ Auto ☐ Fall ☐ Home injury

☐ Chronic Discomfort ☐ Other

Please explain: _____

When did this condition begin? _____

Has this condition:

☐ Gotten worse ☐ Gotten better

☐ Stayed constant ☐ Comes and goes

Does this condition interfere with:

☐ Sleep ☐ Daily routine ☐ Other activities

Please explain: _____

Has this condition occurred before?

☐ Yes ☐ No

Please explain: _____

Have you seen anyone else for this condition?

☐ Yes ☐ No

Doctor's Name _____

Type of Treatment _____

Result _____

Were you aware that:

- Doctors of Chiropractic work with the nervous system? ☐ Yes ☐ No
- The nervous system controls all bodily functions and systems? ☐ Yes ☐ No
- Chiropractic is the largest natural healing profession in the world? ☐ Yes ☐ No
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ☐ Yes ☐ No

Child's Current Health Status

Is your child accident prone? ☐ Yes ☐ No

Has your child:

Been hospitalized? ☐ Yes ☐ No

Had a severe fall? ☐ Yes ☐ No

Been in a car accident? ☐ Yes ☐ No

Has your child taken antibiotics? ☐ Yes ☐ No

If yes, please explain: _____

Is your child currently taking any medication? ☐ Yes ☐ No

If yes, please explain: _____

Does your child have difficulty interacting with schoolmates or friends? ☐ Yes ☐ No

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behaviour? ☐ Yes ☐ No

What changes (if any) in your child's health or behaviour would you like to accomplish? _____

Family Health History

- | | |
|-------------------------------------|-------------------------------------------|
| <input type="radio"/> Diabetes | <input type="radio"/> High Blood Pressure |
| <input type="radio"/> Cancer | <input type="radio"/> Arthritis |
| <input type="radio"/> Stroke | <input type="radio"/> Other: _____ |
| <input type="radio"/> Heart Disease | _____ |

Vaccinations

Have you chosen to vaccinate your child?

☐ Yes ☐ No

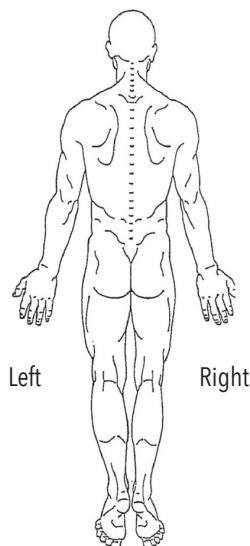
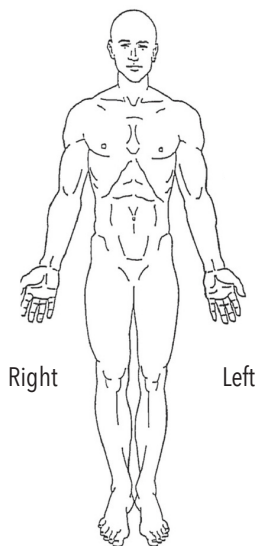
If yes, please check all vaccinations the child has received:

- | | |
|---------------------------------|------------------------------------|
| <input type="radio"/> DPT | <input type="radio"/> MMR |
| <input type="radio"/> Polio | <input type="radio"/> Chicken Pox |
| <input type="radio"/> Hepatitis | <input type="radio"/> Other: _____ |

Describe any and all reactions to vaccine(s):

Type of Pain: ☐ Stiffness ☐ Burning ☐ Numb/Tingling ☐ Sharp ☐ Soreness/Achy

Mark the areas of pain on the figures below and then circle on the pain scale from 0-10 the pain the child feels with this condition. 10 being the worst pain they have ever felt and 0 being no pain at all.



Neck Pain

0 1 2 3 4 5 6 7 8 9 10

Shoulder, Arm Pain

0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain

0 1 2 3 4 5 6 7 8 9 10

Low Back Pain

0 1 2 3 4 5 6 7 8 9 10

Hip, Leg Pain

0 1 2 3 4 5 6 7 8 9 10

Foot, Ankle Pain

0 1 2 3 4 5 6 7 8 9 10

Other Pain

Child's Health History

Please check each of the diseases or conditions that the child has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis.

- | | | | |
|------------------------------------------|------------------------------------------|------------------------------------------|------------------------------------------|
| <input type="radio"/> Vision problems | <input type="radio"/> Allergies | <input type="radio"/> Pink Eye | <input type="radio"/> Colic |
| <input type="radio"/> Headaches | <input type="radio"/> Breathing problems | <input type="radio"/> Ear problems | <input type="radio"/> Digestive problems |
| <input type="radio"/> Sleeping disorders | <input type="radio"/> Hyperactivity | <input type="radio"/> Tubes in the ears | <input type="radio"/> Other: _____ |
| <input type="radio"/> Irritability | <input type="radio"/> Constipation | <input type="radio"/> Attention problems | _____ |
| <input type="radio"/> Skin problems | <input type="radio"/> Bed wetting | <input type="radio"/> Frequent colds | _____ |

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 adjustments, 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 headaches, 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 care 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.

- **Sprain or strain**

Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the affected area 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 or that 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 a 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

Chiropractic Center for Health

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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 traveling 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 with 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 changes in your condition.

DO NOT SIGN THIS FORM UNTIL YOU HAVE MET WITH THE CHIROPRACTOR

I hereby acknowledge that I have 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 the risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

Patient Name (please print)

Alberta Health Care #

Name of Legal Guardian (please print)

Signature of Legal Guardian

Date

Signature of Chiropractor

Date