Pediatric History Form

(For Children 12 years and under)

IT IS A PLEASURE TO WELCOME YOU TO OUR FAMILY OF HAPPY AND HEALTHY CHIROPRACTIC PATIENTS HERE AT GODERICH CHIROPRACTIC. PLEASE LET US KNOW IF THERE IS ANY WAY WE CAN MAKE YOU AND YOUR FAMILY FEEL MORE COMFORTABLE. TO HELP US SERVE YOU BETTER, PLEASE COMPLETE THE FOLLOWING INFORMATION. WE LOOK FORWARD TO WORKING WITH YOU TO CREATE BETTER HEALTH FOR YOUR FAMILY.

(Please Print)

PATIENT NAME:_______________ NAME YOU PREFER US TO USE:_______________

ADDRESS:_______________ CITY:_______________ POSTAL CODE:_______________

HOME PHONE:_______________ CELL:_______________

DATE OF BIRTH:_______________ ☐ MALE ☐ FEMALE WEIGHT:________ HEIGHT:__________

PARENTS/GUARDIANS NAME(S):_______________ REFFERED BY:_______________

PURPOSE FOR CONTACTING US:_______________

HAVE OTHER DOCTORS BEEN SEEN FOR THIS CONDITION? ☐ YES ☐ NO

IF YES, LIST DOCTOR NAME(S AND TREATMENTS:_______________

____

ANY OTHER HEALTH PROBLEMS?:_______________

CHECK ANY OF THE FOLLOWING CONDITIONS YOUR CHILD HAS EXPERIENCED DURING THE PAST 6 MONTHS:

☐ EAR INFECTIONS	☐ DIGESTIVE PROBLEMS	☐ CAR ACCIDENT	☐ HEADACHES
☐ ASTHMA/ALLERGIES	☐ BED WETTING	☐ CHRONIC COLDS	☐ GROWING PAINS /BACK PAIN
☐ COLIC	☐ SEIZURES	☐ RECURRING FEVERS	☐ AUTISM
☐ SCOLIOSIS	☐ ADD/ADHD	☐ TEMPER TANTRUMS	☐ OTHER:__________

FAMILY HISTORY:_______________

PREVIOUS CHIROPRACTOR (IF ANY):_______________ DATE OF LAST VISIT:_______________

REASON:_______________

WERE YOU SATISFIED WITH THE CARE YOUR CHILD HAS RECEIVED THERE? ☐ YES ☐ NO

NAME OF PEDIATRICIAN/DOCTOR:_______________ DATE OF LAST VISIT:_______________

REASON:_______________

WERE YOU SATISFIED WITH THE CARE YOUR CHILD HAS RECIEVED THERE? ☐ YES ☐ NO

NUMBER OF ANTIBIOTICS YOUR CHILD HAS TAKEN DURING THE PAST 6 MONTHS:___DURING LIFETIME:___

NUMBER OF DOSES OF OTHER PRESCRIPTION MEDICATIONS YOUR CHILD HAS TAKEN IN THE PAST 6 MONTHS._______________

DURING HIS/HER LIFETIME:_______________ PLEASE LIST:_______________

VACCINATION HISTORY:_______________

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

LOCATION OF BIRTH: ☐ HOSPITAL ☐ BIRTHING CENTRE ☐ HOME

BIRTH INTERVENTION: ☐ FORCEPS ☐ VACCUUM 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:__________ WHAT TYPE:__________
INTRODUCED SOLIDS AT __________ MONTHS INTRODUCED COWS MILK AT __________ MONTHS
FOOD/JUICE ALLERGIES OR SENSITIVITIES: ☐ YES ☐ NO LIST:____________________

DEVELOPMENTAL HISTORY:

DURING THE FOLLOWING DEVELOPMENTAL STAGES COUR 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 ALONE:______ WALK ALONE:______

HAS YOUR CHILD EVER HAD A HEAD FIRST FALL: ☐ YES ☐ NO

IS/HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT OR CONTACT SPORTS (EX. SOCCER, FOOTBALL, GYMNASTICS, BASEBALL, CHEERLEADING, MARTIAL ARTS, HOCKEY, RINGETTE, ETC.?)
☐ YES ☐ NO LIST:____________________

HAS YOUR CHILD BEEN INVOLVED IN A CAR ACCIDENT?: ☐ YES ☐ NO LIST:____________________
HAS YOUR CHILD BEEN SEEN ON AN EMERGENCY BASIS?: ☐ YES ☐ NO LIST:____________________
OTHER TRAUMAS NOT DESCRIBED ABOVE? ☐ YES ☐ NO LIST:____________________
PRIOR SURGERY: ☐ YES ☐ NO LIST:____________________

Patient Name:____________________

CHILDHOOD DISEASES: PLEASE MARK ALL THAT APPLY:

□ CHICKEN POX	AGE:________	□ MUMPS	AGE:____________
□ RUBELLA	AGE:________	□ WHOOPING COUGH	AGE:____________
□ RUBEOLA	AGE:________	OTHER(S):____________	

WE ARE HERE TO SERVE YOU AND WE ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR CHILD'S RESULTS.

AUTHORIZATION FOR CARE FOR MINOR

I HEREBY AUTHORIZE GODERICH CHIROPRACTIC, IT'S DOCTORS AND STAFF TO ADMINISTER CHIROPRACTIC CARE TO MY SON/DAUGHTER 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.

NAME OF PARENT/GUARDIAN:____

SIGNATURE OF PARENT/GUARDIAN:______________________________ DATE:______________

Dr. Tricia Denunzio, D.C.
34 Kingston Street
Goderich, Ontario
N7A 3K1
Phone (519) 440-5071 Fax (519) 440-5073
drdenunzio@goderichchiropractic.com

I hereby authorize the doctors in this clinic to examine my condition and render care as deemed necessary.

I have listed below an emergency and/or alternate contact with whom this office may communicate, if I can not be contacted personally, or in the event of an emergency. Under such circumstances only, this office has my consent to identify me as a patient to the contact named below.

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that fees for professional services are due when rendered. I understand that if I suspend or terminate my care, any fees for professional services rendered will become immediately due and payable.

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

____.

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

____

(Signature) ***I have read and understand the above*** (Date)

____

(Signature of legal guardian if under the age of 18 years) (Date)

Alternate Address

□ Permanent □Temporary □ Parent □ Not Applicable

Name ____________________

Address ____________________ Apt. # ________

City ____________________ Prov. ____________________

Postal Code ______________ Telephone ________________

Emergency Contact

Name of a relative or close friend <u>NOT</u> living at my own address(es)

Name ____________________

Address ____________________

Telephone ____________________

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 course of 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.

________________________	________________________
Print Patient's Name	Signature of Patient (or parent/guardian)
________________________	________________________
Witness to Signature above	Date Signed

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