# Gordon Street Chiropractic Centre
403 Arkell Road, Unit #6
Guelph, ON N1L 1E5
Office: (519) 837-0411 Fax: (519) 780-1419


## Child History Form

Date: _____

Child's Name _____ Home telephone_____
Address _____ Date of Birth _____
City _____ Province _____ Postal Code _____
Gender: ☐ Male ☐ Female Current Age_____

Medical Doctor's Name _____
Date of Last visit (dd/mm/yy)_____
Child's Height _____ Child's Weight_____
Name(s) of Parent(s) or Guardian(s) _____
Home Phone_____ Business Telephone_____

Has your child seen a chiropractor before? ☐ Yes ☐ No
If so, who?_____ When? _____

Is this a wellness health check-up? ☐ Yes ☐ No
What are your chief concerns, if any, with your child's health? _____
_____
What is your main reason for contacting us?_____
_____
List any other care your child has undergone with regards to this complaint, including medication?
_____
_____
_____

Date of Onset (mm/yyyy)_____

Onset was (circle one)
Sudden Gradual Associated with an event

Duration of problem or episode (circle one)
Minutes Hours Days Months Years

Pattern of Problem (circle one)
Constant Intermittent Occasional Cyclical

Initiating Factors _____
Aggravating Factors_____
Relieving Factors_____
How does the problem affect your child's body function and daily activities?_____
_____
Prior occurrence or episodes?_____
Other health concerns?_____
What kind of stress does this place on your family? _____

# History of Birth

Hospital_____ ☐ Home ☐ Midwife Duration of Gestation_____wks
Was the birth assisted ☐ Yes ☐ No Duration of Labour_____
If yes, how? ☐ Forceps ☐ Vacuum Extraction ☐ C-section ☐ Induced Labour
Were medications given to the mother during Labour? ☐ Yes ☐ No If yes, what? _____
Was the delivery normal? ☐ Yes ☐ No
If no, what complications were there at birth?_____
APGAR at Birth_____ APGAR after 5 mins_____ Birth Weight_____ Birth Length_____

## Growth and Development

Was the infant alert and responsive within 12 hours of the delivery? ☐ Yes ☐ No
If no, explain _____
At what age did the child: Respond to sound?_____ Follow an object?_____ Hold up head?_____
Vocalize?_____ Sit alone?_____ Teethe?_____ Crawl?_____ Walk?_____
Do his/her sleeping patterns seem normal? ☐ Yes ☐ No
Describe any health problems that exist on the mother's side of the family (e.g. Cancer, Diabetes, etc.)
_____
_____
The father's side:_____
_____
Do the child's siblings have any health problems? ☐ Yes ☐ No If yes, describe_____
_____

***The following information is very important because many of the problems that chiropractors work with are caused by stressors***

## Chemical Stressors

During pregnancy, did the mother: 1. Smoke? ☐ Yes ☐ No 2. Drink alcohol? ☐ Yes ☐ No
3. Take supplements/vitamins? ☐ Yes ☐ No
4. Become ill? ☐ Yes ☐ No If so, how? _____
5. Take drugs? ☐ Yes ☐ No If yes, what?_____
6. Receive ultrasounds? ☐ Yes ☐ No If yes, how many?_____
7. Receive invasive procedures (i.e. amniocentesis, CVS)? ☐ Yes ☐ No
Was your child breast fed? ☐ Yes ☐ No If yes, for how long?_____ wks months years
If no, what was used as a supplement? _____
Did your child receive vaccinations? ☐ Yes ☐ No If yes, which ones: _____
_____Did your child react to them? ☐ Yes ☐ No
Has your child had antibiotics? ☐ Yes ☐ No If yes, how many courses has the child had so far and why:_____
Any pets at home? ☐ Yes ☐ No Any smokers at home? ☐ Yes ☐ No

## Psychological Stressors

Any difficulties with lactation? □ Yes □ No Any problems bonding? □ Yes □ No
Does your child seem normal to you? □ Yes □ No
Does your child have any behavior problems? □ Yes □ No If yes, what? _____
_____
Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? □ Yes □ No
If yes, explain_____
Did your child go to daycare? □ Yes □ No From what age? _____yrs
Average number of hours of TV/Computer per week? _____hrs
Has there been a stressful event(s) in the child's life? (i.e. death of parent/grandparent, divorce, family illness?)_____
Do you have any concerns about your child's performance at school? □ Yes □ No
If yes, explain_____
_____

## Traumatic Stressors

Any evidence of trauma during birth? □ Bruises □ Odd shaped head □ Stuck in birth canal
□ Fast and/or excessively long birth □ Respiratory Depression □ Cord around neck
□ Other_____
Any falls/accidents during pregnancy? □ Yes □ No
Has the child had any major falls since birth? □ Yes □ No If yes, did the child need stitches or cause a fracture? Please describe_____
Any hospitalizations? □ Yes □ No Please explain_____
_____
Does your child play sports? □ Yes □ No No. of hours per week?____ Age child began___yrs
Weight of school backpack?_____lbs Approx. hours spent at play per week?_____hrs

Is there anything else you would like to share about your child? _____
_____
_____
_____
_____

## Check any of the following conditions your child has had:

| | | |
|---|---|---|
| □ Measles | □ Eczema | □ Vomiting |
| □ Mumps | □ Epilepsy | □ Diarrhea |
| □ Whooping cough | □ Diabetes | □ Constipation |
| □ Chicken pox | □ Cancer | □ Vision problems |
| □ Polio | □ Thyroid | □ Dental problems |
| □ Rheumatic fever | □ Allergies/Asthma | □ Sore throat |
| □ Small pox | □ Headaches | □ Ear aches |
| □ Influenza | □ Convulsions | □ Hearing difficulty |
| □ Pneumonia | □ Heart problems | □ Stuffed nose/sinus infection |

# Informed Consent to Chiropractic Treatment

**Consent to Examination**

Your chiropractic care at this office will be based upon the details of your personal health history, as well as detailed orthopedic, chiropractic ad neurological and potentially x-ray examinations. During the course of these examinations the chiropractor will be asking you to bend, twist and move and undergo a physical examination in which the doctor will feel areas of your spine and muscles.
I have read the above and consent to undergoing the above listed examinations.

| _____ | _____ | _____ |
|---|---|---|
| Print name | Signature | Date |

**Consent to Treatment**

Chiropractors locate, analyze and correct vertebral subluxations, which are misalignments of spinal joints, which cause nervous system imbalances. Chiropractic treatment, including spinal adjustments, have been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be a highly effective treatment for spinal pain, headaches, and other similar symptoms. Chiropractic care can greatly contribute to your overall well-being and good health. Chiropractors utilize chiropractic adjustments, soft tissue therapy and occasionally modalities such as Ultrasound and Interferential current to treat your condition.

Chiropractic care is considered to be one of the safest forms of health care; the risk of injuries of complications from chiropractic treatment is substantially lower than that associated with medical or other treatment, medications and procedures given for the same symptoms. However, all treatment contains some risks you should be aware of. These include ligament sprains, muscle strains, rib fractures, and disc injuries. Additionally, cervical spine adjustments can carry the extremely remote complication of vertebral artery injury resulting in stroke. We will do our very best to minimize these risks through thorough examination and screening practices.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, my treatment in particular, and the risks associated.

I have read the above consent and by signing below I consent to chiropractic treatment at this office. I intend this consent to apply to all my present and future chiropractic care.

| _____ | _____ | _____ |
|---|---|---|
| Print name | Signature | Date |

DC's initials_____