

CONFIDENTIAL CASE HISTORY – CHILDREN’S VERSION (age 2-12)

THE IMPORTANCE OF THIS EXAMINATION

DATE: _____

It is a pleasure to welcome you to Discover Chiropractic Family Wellness Centre. **The fee for today’s examination is \$50** (unless special arrangements have been previously discussed). The purpose of today’s visit is to provide what will likely be the most complete physical and neurological examination your child has ever had. **Except in EXCEPTIONAL circumstances NO adjustments will be performed** until the file has been carefully analyzed and the findings presented (usually on your next visit). This approach is consistent with any significant health-related procedure. You will find that the two things we never compromise are YOUR HEALTH and OUR REPUTATION.

MSP Care Card PHN# _____ Last Name _____ First Name _____

Birthdate (M/D/Y) _____ Age _____ (in years) Female ____ Male ____

Address _____ City _____ Postal Code _____

Name of Parents _____

Parent’s: Home Phone _____ Work Phone _____ Email Address _____

Names and ages of siblings _____

How did you find out about our office? _____

If you were referred to our office, whom may we thank? _____

The human body is designed to be healthy. The primary system in the body that coordinates health is the nervous system – often called the “Master System”. Beginning with the birth process until the present, events may have happened in your child’s life to cause interference and damage to this master system. This form will help reveal these events and direct the doctor in performing the most appropriate examination and subsequent adjustments to help restore your child to optimum function.

PURPOSE OF TODAY’S VISIT

Because chiropractic focuses on function and not disease, your child (and the rest of your family) does not need to have symptoms to benefit from care. Please indicate the reason for your child’s visit today:

1. Spinal screening and wellness check
2. Accident or Fall. Please describe _____
3. Illness or other health problem. Please describe _____

Have other doctors/therapists been consulted for this condition? Yes No _____

CURRENT AND PAST HEALTH HISTORY

1. Doctors of Chiropractic are the only doctors trained to detect and correct vertebral subluxations (abnormally functioning spinal joints).

Has your child ever been checked by a Doctor of Chiropractic? Yes No Date of your last visit _____

Would you rate your experience as positive, negative or neutral? _____ Why? _____

2. According to the National Safety Council approximately 50% of infants have fallen onto their heads in the first year of life. Another study reveals that 250,000 children are injured yearly in playgrounds.

Can you recall any such jolts, falls or traumas to your child? Yes No

Please describe: _____

3. Experts around the world agree that the birth process as we know it may cause extensive neurological trauma, damage and even death. Please circle where applicable.

- Did mother have ultrasound during the pregnancy? **Yes** **No** If yes, how many and why? _____
- Did mother smoke or drink alcohol during pregnancy? **Yes** **No**
- Place of birth: Home/ Birthing Centre/ Hospital/ Other _____
- Provider: Midwife/ Ob-Gyn/ Other _____
- Type of Birth: Vaginal/ C-Section (emergency or planned)/ Breech
- Was anaesthesia used? **Yes** **No** If yes, what type? Epidural/ IV/ Other _____
- Was labour induced? **Yes** **No** If yes, why? _____
- Birth Trauma: Doctor assisted/ Forceps/ Vacuum extraction/ Twisting, Pulling

4. Repeated studies are now informing us that breast-feeding develops strong and healthy immune, neurological and digestive systems.

Was your child breast-fed? **Yes** **No** If yes, how long? _____
Does your child have any food intolerances? **Yes** **No** If yes, what? _____
Does your child consume any foods with caffeine or artificial sweeteners (aspartame, nutrasweet) **Yes** **No**
How would you rate your child's diet? Good/ Average/ Poor

5. While chiropractic does not treat disease it does reduce stress, enhance immunity, and regulate the function of the master system – the nervous system. In this way many symptoms are alleviated. Please circle any of the following conditions your child has suffered from:

Colic, Irregular Sleeping Patterns, Night Terrors, Seizures, Tantrums, Ear Infections, Allergies, Asthma, Headaches, Poor Digestion, Repeated Infections or Colds, Bed Wetting, Learning Disorders, Emotional Disorders, ADD or ADHD, Other _____

6. Does your child play any of the following high-impact sports (please circle):

Soccer, Football, Gymnastics, Martial Arts, Hockey, Lacrosse, Basketball, Dance, Wrestling, Baseball, Other _____

7. If your child is of school age we know that he or she will sit for five or more hours per day.

Other than this does your child sit for extended periods of time in front of a computer or television? **Yes** **No**

8. We now know that over 90% of ear infections are due to viral infections and the use of antibiotics does nothing to shorten or reduce the infection. The indiscriminate use of antibiotics DOES however make your child more susceptible to future infections and adds to the problem of drug-resistant bacteria.

Is your child currently taking any medications? **Yes** **No** Please list _____
Has your child ever been prescribed antibiotics? **Yes** **No** How many times/what type? _____
Has your child ever been prescribed any other drugs? **Yes** **No** Please list _____
Were you given adequate information on the possible adverse reactions? **Yes** **No**
Has your child had any surgery? **Yes** **No** Please list _____

9. Your child's immune system, like all other developing systems, is both intricate and delicate. Given the proper environment it will naturally develop life-long immunity to most childhood diseases. The process of vaccination seeks to provide artificial immunity, which is significantly different, requires periodic boosters and may in fact be harmful to your child's health.

Has your child been vaccinated? **Yes** **No** Please list _____
Were you adequately advised of the risks and benefits of each vaccine? **Yes** **No**
Did your child experience any emotional, physical, neurological or behavioural changes within 3 months of any vaccination? **Yes** **No** Please describe _____

Thank you for taking the time to completely and accurately fill out this form. We are here to serve you and encourage you to ask questions. Should you ever have any concerns please feel free to bring them up.