thrive chiropractic Unit 50-1580 Taylor Ave|Winnipeg|R3N 2A7 P. 204-504-life (5433)

PEDIATRIC HEALTH HISTORY

In order to give your child the best care possible, please complete this health history as thoroughly as possible. All information is strictly confidential. The doctor will review this history and with your consent do a complete examination to determine how Chiropractic care may help your child.

Today's Date: _____

Patient Data

Full Name: _____ Name of Parents: _____ Sex: ☐ M ☐ F
Address: _____ City: _____ Prov:____ Postal Code: _____
Telephone: (Home)_____ (Cell)_____
Birthdate: _____ (M/D/Yr) Age: _____
Name of Pediatrician: _____ Telephone Number: _____

Has your child received Chiropractic care before? ☐ Yes ☐ No
If yes: With Whom: _____ When: _____
Manitoba Health Number (6 Digit): _____ (9 digit): _____

About Your Childs Health

The human body is designed to be healthy. There are many events that occur and habits we develop that affect how well our bodies are able to adapt and heal. This, in turn, affects how truly healthy we are, even without any signs or symptoms.

Main *goal* in consulting our office for your child:

☐ Correction and resolution of existing problem

☐ Prevention/ Healthy check-up (Please skip to next section)

Main *reason* (health concern) for consulting our office:

_____

Did your child's complaint(s) arise from a *Motor Vehicle Accident (MPI)*? ☐ Yes ☐ No
If yes, date of injury? _____ Collision type (i.e. rear-ended) _____Claim #_____
Name and phone number of *adjuster*? _____

If complaint is due to an action or event, please explain:

_____

_____

How long have they had this condition? ____ Days, ____ Weeks, ____ Months, or ____Years

Did the complaint(s) come on: ☐ Suddenly ☐ Gradually

Is the complaint(s) getting: ☐ Same ☐ Better ☐ Worse

If your child has pain, is it: ☐ Mild/dull ache ☐ Moderate ☐ Severe ☐ Throbbing ☐ Sharp/stabbing

Is the condition worse in the: ☐ Morning ☐ Evening ☐ At school ☐ At Night ☐ Constant

Is the complaint: ☐ Constant ☐ Intermittent ☐ Worse with movement

Does the condition interfere with: ☐ Sleep ☐ School ☐ Walking ☐ Exercise ☐ Other _____

What seems to aggravate their condition/pain?

_____

What (if anything) relieves their condition/pain?

_____

If they have or are currently receiving other treatment, please describe type of treatment and results:

_____

_____

Other Symptoms and Conditions

Has your child experienced any of the following:

☐ Headaches	☐ Ear Infections	☐ Back/neck pain	☐ Asthma/allergies
☐ Colic	☐ Loss of balance	☐ Fainting	☐ Chronic colds/flu
☐ Digestive problems	☐ Bed Wetting	☐ Growing pains	☐ Sleep problems
☐ Recurring fevers	☐ Seizures	☐ Depression	☐ Autism
☐ Asberger's Syndrome	☐ Scoliosis	☐ Poor concentration	☐ Mood swings
☐ ADHD	☐ Other		

Please list any medications they are receiving:

_____

_____

Please list any surgeries: (Type and date)

_____

_____

Has your child had any of the following in the last two years? ☐ X-rays ☐ CT Scan ☐ MRI ☐ Bone Scan

☐ Bone Density test If yes, when and which area(s) of body? _____

Events and Habits

Many symptoms or health concerns experienced have roots in stresses or injuries from the developmental years. Some as early as the birth process.

In-Utero	**Yes**	**No**	**Date and/or pertinent details**
Complications during the pregnancy?	☐	☐	_____
Falls or injuries to the mother?	☐	☐	_____

Medications used during pregnancy?	☐	☐	_____
Smoke or drink alcohol?	☐	☐	_____

Birth process	**YES**	**No**	**Date and/or pertinent details**
Long/difficult delivery?	☐	☐	_____
Use of forceps/vacuum extractor?	☐	☐	_____
Caesarian section (planned or emergency)?	☐	☐	_____
Breach/cephalic?	☐	☐	_____
Mother given drugs/epidural?	☐	☐	_____
Induced labour?	☐	☐	_____

Childhood			
Any notable falls or sports injuries?	☐	☐	_____
Any significant illnesses?	☐	☐	_____
Any prolonged medications?	☐	☐	_____
Does he/she exercise regularly?	☐	☐	_____
☐ Daily ☐ Weekends ☐ Occasional			
Does he/she eat as healthy as they should?	☐	☐	_____
Healthy weight?	☐	☐	_____
Poor posture?	☐	☐	_____
Extended hours at a computer?	☐	☐	_____
Involved in any high impact sports?	☐	☐	_____
Have high emotional stress?	☐	☐	_____
Take nutritional supplements?	☐	☐	_____

Sleeping posture

☐ Side ☐ Back ☐ Stomach

Consent for Communication/Release of Information

I hereby authorize and grant permission to the above-named office to communicate with **other health care professionals**, and/or **Manitoba Public Insurance** or the **Worker's Compensation Board** (if applicable), with respect to my care and progress.

_____ Date: _____

Signature of parent or legal guardian

Consent to Evaluate and Treat a Minor

I _____, being the parent or legal guardian of _____, hereby grant permission for my child to receive a chiropractic evaluation, X-ray evaluation (if necessary to determine treatment protocol) and subsequent treatments by the Doctor(s) of Thrive Chiropractic.

_____ Date: _____

Signature of parent or legal guardian