

# In-Joy Life Wellness Group Child History Form (16 and under)



Please complete the following health history form and if you need assistance, please ask the front desk staff and they will be glade to assist you.

Child's Name \_\_\_\_\_ Date \_\_\_\_\_  
Parent(s) Name \_\_\_\_\_  
Siblings Names (Ages) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_  
Postal Code \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Bus Phone (\_\_\_\_) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Referred by \_\_\_\_\_  
M/D/Y

Has your child ever received chiropractic care? **Yes No**

If yes, previous DC's name and list visit date? \_\_\_\_\_

Name of medical Doctor \_\_\_\_\_

Date of last MD visit and reason \_\_\_\_\_

### AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

PARENT(S) NAMES \_\_\_\_\_ WORK TEL \_\_\_\_\_

(Please Print)

I hereby authorize and consent to the chiropractic evaluation of my child.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

WITNESS SIGNATURE \_\_\_\_\_

### PRESENT HEALTH COMPLAINTS/CONCERNS:

Major \_\_\_\_\_

Minor \_\_\_\_\_

When did this problem begin? \_\_\_\_\_

Is this problem (circle) *occasional* *frequent* *content* *intermittent*

Does problem radiate? **Yes No** If yes, where? \_\_\_\_\_

What makes this worse? \_\_\_\_\_

What makes this better? \_\_\_\_\_

Is this problem worse during a certain time of the day? **Yes No**

If yes, when? \_\_\_\_\_

Does this interfere with the child's sleep? \_\_\_\_\_ Eating? \_\_\_\_\_ Daily routine? \_\_\_\_\_

Is this becoming worse? \_\_\_\_\_

Other professionals seen for this condition? \_\_\_\_\_

Results with that treatment? \_\_\_\_\_

CONCERNS: (please place a check mark if your child has had any of the following)

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> headaches             | <input type="checkbox"/> loss of taste        | <input type="checkbox"/> weight gain         | <input type="checkbox"/> upper back pain     |
| <input type="checkbox"/> dizziness             | <input type="checkbox"/> light sensitivity    | <input type="checkbox"/> dental problems     | <input type="checkbox"/> neck pain           |
| <input type="checkbox"/> fainting              | <input type="checkbox"/> face flushed         | <input type="checkbox"/> fevers              | <input type="checkbox"/> low back pain       |
| <input type="checkbox"/> irritability          | <input type="checkbox"/> cold sweats          | <input type="checkbox"/> heart palpitations  | <input type="checkbox"/> radiating pain      |
| <input type="checkbox"/> depression            | <input type="checkbox"/> bronchitis           | <input type="checkbox"/> chest pressure      | <input type="checkbox"/> stiffness           |
| <input type="checkbox"/> loss of balance       | <input type="checkbox"/> pneumonia            | <input type="checkbox"/> foot pain           | <input type="checkbox"/> reduced mobility    |
| <input type="checkbox"/> loss of concentration | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> frequent colds      | <input type="checkbox"/> numbness in leg(s)  |
| <input type="checkbox"/> loss of memory        | <input type="checkbox"/> shortness of breath  | <input type="checkbox"/> sinus               | <input type="checkbox"/> numbness in feet    |
| <input type="checkbox"/> ears buzzing          | <input type="checkbox"/> asthma               | <input type="checkbox"/> throats             | <input type="checkbox"/> numbness in hand(s) |
| <input type="checkbox"/> poor condition        | <input type="checkbox"/> urinary problems     | <input type="checkbox"/> ear pain/infections | <input type="checkbox"/> weakness            |
| <input type="checkbox"/> vision changes        | <input type="checkbox"/> constipation         | <input type="checkbox"/> allergies           | <input type="checkbox"/> muscle cramps       |
| <input type="checkbox"/> loss of smell         | <input type="checkbox"/> diarrhea             | <input type="checkbox"/> heartburn           | <input type="checkbox"/> sleeping problems   |
|  | <input type="checkbox"/> Weight loss          | <input type="checkbox"/> bloating/gas        |  |
- Other: \_\_\_\_\_

### **HISTORY OF BIRTH**

What was the child's gestational age at birth? \_\_\_\_\_ weeks.

Birth weight \_\_\_\_\_ lbs \_\_\_\_\_ oz

Was your child's birth (circle one) at home, in a birthing centre or in a hospital?

Was the birth considered (circle one) medical or midwife?

What was the duration of the labor and birth? \_\_\_\_\_ hours

Was child born (circle one) cephalic (head first) or breech (feet first)?

Were there any complications? **Yes** **No** If yes, please explain \_\_\_\_\_

Please circle any assistance which was used during birth

***Forceps***      ***Vacuum extraction***      ***C-section***      ***Episiotomy***

Was labor (circle one) spontaneous or induced?

Were medications or epidurals given to the mother during birth? **Yes** **No**

If yes, what was given \_\_\_\_\_

APGAR score: at Birth \_\_\_\_\_/10      After 5 minutes \_\_\_\_\_/10

### **GROWTH AND DEVELOPMENT**

Was the infant alert and responsive within 12 hours of delivery? **Yes** **No**

If no, please explain \_\_\_\_\_

At what age did your child:	Respond to sound	_____	Follow an object	_____
	Hold up head	_____	Vocalize	_____
	Sit alone	_____	Teethe	_____
	Crawl	_____	Walk	_____

Do you consider the child's sleeping pattern normal? **Yes** **No** If no, please explain \_\_\_\_\_

**FAMILY HEALTH HISTORY**

Please note any health problems (i.e. Cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:

Mother's family \_\_\_\_\_

Father's family \_\_\_\_\_

Siblings \_\_\_\_\_

**Since problems that chiropractic look for and detect can be related to many types of stressors, the following information is also very important to us.**

**PHYSICAL STRESSORS**

Any traumas to the mother during pregnancy? (i.e. falls, accidents, etc.) **Yes** **No**

Please explain \_\_\_\_\_

Any evidence of birth trauma to the infant? (Please tick)

\_\_\_ *Bruising*

\_\_\_ *Odd shaped head*

\_\_\_ *Stuck in birth canal*

\_\_\_ *Fast or excessively long birth*

\_\_\_ *Respiratory depression*

\_\_\_ *Cord around neck*

Any falls from couches, beds, change tables, etc? **Yes** **No**

If yes, please explain \_\_\_\_\_

Any traumas resulting in bruises, cuts, stitches or fractures? **Yes** **No**

Any hospitalizations or surgeries? **Yes** **No**

If yes, please explain \_\_\_\_\_

Any sports played? \_\_\_\_\_

Is a school backpack used? **Yes** **No** Is it **heavy** or **light**? (circle one)

**CHEMICAL STRESSORS**

Was this child breast-fed? **Yes** **No** If yes, how long? \_\_\_\_\_

Formula introduced at what age? \_\_\_\_\_ Which formula? \_\_\_\_\_

Introduction of cow's milk at what age? \_\_\_\_\_

Began solid foods at what age? \_\_\_\_\_

Food/Juices intolerance? **Yes** **No** Type? \_\_\_\_\_

During pregnancy, did the mother Smoke? **Yes** **No** How much? \_\_\_\_\_

Drink? **Yes** **No**

Any illnesses during the pregnancy? **Yes** **No**

List \_\_\_\_\_

Any supplements taken during pregnancy? **Yes** **No**

List \_\_\_\_\_

Any drugs taken during pregnancy? *Yes No*

List \_\_\_\_\_

Any ultrasounds? *Yes No* How many and reasons for being done? \_\_\_\_\_

Any invasive procedures during pregnancy (i.e. amniocentesis, CVS, etc.)? *Yes No*

Please explain \_\_\_\_\_

Any pets at home? *Yes No*

Types \_\_\_\_\_

Any smokers in the home? *Yes No*

Vaccination history Vaccination and age given? \_\_\_\_\_

Any negative reactions? *Yes No* \_\_\_\_\_

Any antibiotics given? *Yes No* \_\_\_\_\_

### **PSYCHOSOCIAL STRESSORS**

Any difficulties with lactation? *Yes No* \_\_\_\_\_

Any problems with bonding? *Yes No* \_\_\_\_\_

Any behavioral problems? *Yes No* \_\_\_\_\_

Any night terrors, sleep walking, difficulty sleeping? *Yes No* \_\_\_\_\_

Age of child when began daycare? \_\_\_\_\_

Average number of hours of television per week? \_\_\_\_\_

Do you feel that you child's social and emotional development is normal for there age? *Yes No*

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below.

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**INFORMED CONSENT TO CHIROPRACTIC  
EXAM &/OR CARE**  
In-Joy Life Wellness Group

There are risks and possible risks associated with the manual therapy techniques used by doctors of chiropractic. In particular you should note:

- A) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- B) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- C) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
- D) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

**Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_**

**Patient signature (Legal Guardian)**

**Witness of Signature**

**Name:** \_\_\_\_\_  
(Please print)

**Name:** \_\_\_\_\_  
(Please print)