INNER WISDOM
PEDIATRIC HEALTH HISTORY

Dr. J. Randall, B.Sc., DC

300 Willow Rd., Suite 204
Guelph, ON
N1H 7C6
519-763-0090

Name: _____ Birth Date: D_____M____YR_____ Age: _____ Sex: M ☐ F ☐

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Names of Parent(s)/Guardian(s): _____

Pediatrician/Family Doctor's Name and Phone Number: _____

Has your child had previous Chiropractic Care? ☐ None ☐ Name and last visit: _____

Is your child covered by your extended health care insurance (Benefits, Group Insurance)?

☐ No ☐ Yes Amount of Coverage _____

Who may we thank for referring your child to our office? _____

HEALTH PROFILE

As a full service wellness office, our focus is on your child's ability to achieve optimal health. Our goals are to address the issues that brought your child to this office, as well as offering you the opportunity to explore improved health potential and wellness services in the future. On a daily basis your child experiences physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential.

If your child has no symptoms or complaints presently, and is here for wellness services, (√) check here _____ and skip to Past Health Profile. Symptoms or complaints need to be briefly described below.

What is the purpose of this appointment? _____

Other doctors seen for this condition? ☐ No ☐ Yes Who and When? _____

Describe any treatment, therapy, or diagnostics done to date: _____

When did this condition begin? _____ Has it occurred before? ☐ No ☐ Yes When? _____

Is the condition: ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other _____

Date of Accident: _____ (supplemental forms required for motor vehicle accidents)

What aggravates this condition? _____ What relieves this condition? _____

Is this condition: ☐ Becoming Worse ☐ Constant ☐ Comes and Goes ☐ Improving

Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning ☐ Travels to _____

Does this condition interfere with: ☐ School ☐ Sleep ☐ Hobbies/Sports ☐ Happiness/Quality of life

Has your child been prescribed medications for this complaint? Please List: _____

PAST HEALTH PROFILE

Below is a list of symptoms or illnesses which may seem unrelated to the purpose of your child's appointment, however, these questions must be answered carefully, as these conditions may affect your child's overall course of chiropractic care. Check any of the following your child experiences now, or has in the recent (6 months) past:

- ☐ low back pain
- ☐ pain between shoulders
- ☐ scoliosis
- ☐ dizziness
- ☐ diarrhea
- ☐ chewing/jaw problems
- ☐ seizures
- ☐ allergies
- ☐ heartburn
- ☐ ear aches/infections
- ☐ colic
- ☐ asthma
- ☐ frequent nausea
- ☐ vomiting
- ☐ walking problems
- ☐ ADD/ADHD
- ☐ fatigue
- ☐ stress
- ☐ fever
- ☐ colitis
- ☐ poor/excessive appetite
- ☐ excessive thirst
- ☐ arm pain
- ☐ joint pain/stiffness
- ☐ lung congestion
- ☐ general stiffness
- ☐ tingling extremities
- ☐ abdominal cramps
- ☐ sore throat
- ☐ bed wetting
- ☐ stuffed nose
- ☐ neck pain
- ☐ irregular heart beat
- ☐ heart problems
- ☐ constipation
- ☐ temper tantrums
- ☐ weight trouble
- ☐ loss of sleep
- ☐ headaches
- ☐ hearing loss

STRESS INDEX

Answering the following questions will give us a profile of the specific stresses your child has faced in their lifetime, allowing us to better assess the challenges to their health potential. Research is showing that many of the health challenges that occur in later life have their origins during the developmental years, some starting at birth. Please answer to the best of your ability:

Developmental Years:

Was it a long/difficult delivery?	☐ Yes ☐ No	_____
Were forceps/suction used?	☐ Yes ☐ No	_____
Were they breast-fed? How long? _____	☐ Yes ☐ No	_____
Was your child vaccinated?	☐ Yes ☐ No	_____
Any notable falls (out of crib/change table, etc)?	☐ Yes ☐ No	_____
Any significant childhood illnesses?	☐ Yes ☐ No	_____
Any hobby or sports injuries?	☐ Yes ☐ No	_____
Any surgeries or prolonged medication use?	☐ Yes ☐ No	_____
Was your child ever assessed/fitted for orthotics?	☐ Yes ☐ No	_____
Has your child been the victim of mental or physical abuse?	☐ Yes ☐ No	_____
Were they ever involved in a motor vehicle accident?	☐ Yes ☐ No	_____
Any food allergies or intolerances? Please list.	☐ Yes ☐ No	_____
Do they maintain proper posture?	☐ Yes ☐ No	_____

Number of doses of antibiotics your child has taken in: past 12 months: _____ lifetime total: _____

Sleep posture- ☐ Side ☐ Back ☐ Stomach

Ever had: Chicken pox: Y / N Rubella: Y / N Measles: Y / N Mumps: Y / N Whooping Cough: Y / N

At what age were they able to: Respond to sound _____ Hold head up _____ Sit unsupported _____

Crawl _____ Stand unsupported _____ Walk unsupported _____

FAMILY HEALTH PROFILE

As a family oriented wellness centre, we are not only interested in your child's health and well-being, but also the health and well-being of your entire family. Please mention below any health condition or concerns you have about your child's:

	Names and Ages	Condition(s)
Sister(s)	_____	_____
Brother(s)	_____	_____
Mother	_____	_____
Father	_____	_____
Other	_____	_____

ABOUT YOUR CHILD'S CARE

Chiropractic provides three types of care. The first is Initial Intensive Care, which corrects the most recent layer of spinal and neurological damage. This care usually reduces or eliminates symptoms. Then begins Reconstructive/Corrective Care, which corrects the years of damage that occurred when there were few symptoms. Finally, Chiropractic offers a genuine approach to wellness care. Based on these definitions, my child has primarily consulted this office because:

- ☐ I am interested in my child reaching their optimal health potential (Wellness care).
- ☐ My child has a health concern, and I want the cause of this problem corrected and symptoms relieved (Corrective care).
- ☐ I am only interested in their relief from pain (Relief care).

INNER WISDOM
INFORMED PEDIATRIC CONSENT

Dr. J. Randall, B.Sc., DC
300 Willow Rd., Suite 204, Guelph, ON • N1H 7C6 • 519-763-0090

We want your informed consent. This means we want you to understand the services we hope to provide to your child, the cost involved, and what we do with personal information we obtain about them. If you have any questions, please ask.

Chiropractors locate, analyze, and correct by adjustment, **vertebral subluxations** (spinal dysfunctions) which cause nerve interference. Chiropractic adjustments restore function to the nervous system, networked through your entire body, and allow the **innate** healing power of your child's body to work at maximum efficiency in order to restore, maintain, and promote their health.

Physicians, Chiropractors, Osteopaths, and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke like occurrences, which are usually of a temporary nature. Tests, with or without x-rays, will be performed on you to minimize this risk. Chiropractic is considered one of the safest and most effective health care treatments.

I understand that to provide my child with health goods and services, Inner Wisdom will collect some personal information about them (phone number, address). This information may be shared with any other Chiropractor at this office who may administer treatment to my child, or any other therapist or practitioner at Inner Wisdom, as deemed necessary.

I understand that Inner Wisdom has a privacy policy regarding the collection, use and disclosure of personal information, steps taken to protect the information, and my right to review my child's personal information.

I understand that I might receive the following: newsletters, Thank you cards, phone calls, post cards, health packages, etc., that may be of interest to me.

I have read the above, and consent to examination and treatment of my child by Dr. Jeff Randall. I hereby authorize Dr. Randall (or whomever my doctor designates in his absence) to administer appropriate care, as they deem necessary. I clearly understand, and agree that *I am personally responsible for payment of all fees for services rendered by this office, and that accounts are payable when the service is provided.*

Date:_____ Patient's Name: _____

Parent/ Guardian Name: _____

Parent/Guardian Signature: _____

Witness: _____