

**M & Y Chiropractic Health and Wellness Centre**  
**Confidential Pediatric Health History Form**

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M / F

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone# (H): \_\_\_\_\_ Other Phone # \_\_\_\_\_

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth \_\_\_\_\_  
 day month year

Mom's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Dad's Name \_\_\_\_\_ Occupation \_\_\_\_\_

***How were you referred to our clinic?*** \_\_\_\_\_  
 (Person's name, phone book, signs, etc...)

	NAME:	ADDRESS:	PHONE #:
Current Chiropractor:			
Current Massage Therapist:			
Current Naturopath:			
Current Medical Doctor:			

\*\*\*\*\*

**CHIEF CONCERN:**

What is your main reason for coming in today? \_\_\_\_\_

How long? \_\_\_\_\_ Onset? \_\_\_\_\_

What is the frequency? \_\_\_\_\_ How long does it last? \_\_\_\_\_

What makes it better? \_\_\_\_\_ Worse? \_\_\_\_\_

Any previous treatments? \_\_\_\_\_

Any other concerns? \_\_\_\_\_ Past health concerns? \_\_\_\_\_

\_\_\_\_\_

**IMMUNIZATIONS: Please give date of immunization**

Measles, Mumps, Rubella \_\_\_\_\_  Influenza \_\_\_\_\_  Hepatitis \_\_\_\_\_

Diphtheria, Pertussis, Tetanus \_\_\_\_\_  Small Pox \_\_\_\_\_  Polio \_\_\_\_\_

Other \_\_\_\_\_

Any adverse reactions? \_\_\_\_\_

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**FAMILY HISTORY:** Please check appropriate boxes.

	Age	Allergies	Cancer	Hyper-tension	Heart Disease	Arthritis	Diabetes	Mental Illness	Birth Defects	Tuber-culosis	Other
Mother											
Father											
Mom's side – Grandmother											
Mom's side – Grandfather											
Dad's side – Grandmother											
Dad's side – Grandmother											
Siblings (please list)											

**PRENATAL HISTORY:**

Age at conception – Mom: \_\_\_\_\_ Dad: \_\_\_\_\_

Weight gain: \_\_\_\_\_

Any illnesses during pregnancy? (please check).

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Hypertension.      | <input type="checkbox"/> Diabetes.         | <input type="checkbox"/> Pre-eclampsia.               |
| <input type="checkbox"/> Nausea / Vomiting. | <input type="checkbox"/> Infections.       | <input type="checkbox"/> Anemia.                      |
| <input type="checkbox"/> Bleeding.          | <input type="checkbox"/> Thyroid problems. | <input type="checkbox"/> Physical / emotional stress. |

Cigarette / alcohol / drug consumption? How much? \_\_\_\_\_

Supplements / medications? (Please list). \_\_\_\_\_

Any miscarriages or abortions? \_\_\_\_\_

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**BIRTH HISTORY:**

Gestation length: \_\_\_\_\_ Weight at birth: \_\_\_\_\_ Length: \_\_\_\_\_

Length of labour: \_\_\_\_\_  Spontaneous       Induced       C- section       Vaginal

Any complications? \_\_\_\_\_

Any interventions? \_\_\_\_\_

**NEONATEL HISTORY (0 – 2 months):**

Did your infant experience any of the following at birth or soon after? (Please check).

- |                                   |   |   |                                    |
|-----------------------------------|---|---|------------------------------------|
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Feeding problems | <input type="checkbox"/> Hypoxia                  | <input type="checkbox"/> Cyanosis  |
| <input type="checkbox"/> Anaemia  | <input type="checkbox"/> Convulsions      | <input type="checkbox"/> Congenital abnormalities | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Colic    | <input type="checkbox"/> Rashes           | <input type="checkbox"/> Elimination problems     |                                    |

Other? \_\_\_\_\_

**CHILD'S HEALTH HISTORY:**

Has your child had any of the following? (Please check).

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Chickenpox      | <input type="checkbox"/> Mumps                                    | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Rubella         |
| <input type="checkbox"/> Tonsillitis     | <input type="checkbox"/> Pneumonia                                | <input type="checkbox"/> Measles       | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Hives           | <input type="checkbox"/> Frequent colds                           | <input type="checkbox"/> Sore throat   | <input type="checkbox"/> Asthma          |
| <input type="checkbox"/> Eczema          | <input type="checkbox"/> Diarrhoea                                | <input type="checkbox"/> Constipation  | <input type="checkbox"/> Wheezing        |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Frequent vomiting                        | <input type="checkbox"/> Growing pains | <input type="checkbox"/> Fevers          |
| <input type="checkbox"/> Gas / bloating  | <input type="checkbox"/> Ear infections ( <i>How many?</i> _____) |  | <input type="checkbox"/> Rashes          |
| <input type="checkbox"/> Other? _____    |   |  |  |

Any treatment? \_\_\_\_\_

Any allergies? *Please list:* \_\_\_\_\_

Any accidents / injuries? *Please list what happened and when:* \_\_\_\_\_

Hospitalizations? *What for and when?* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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**MILESTONES:***(please state age achieved)*

Sit up: \_\_\_\_\_ Crawl: \_\_\_\_\_ Walk: \_\_\_\_\_ Teeth: \_\_\_\_\_ Talk: \_\_\_\_\_ Puberty: \_\_\_\_\_

**SLEEP:**

Sleep through the night ( \_\_\_\_\_ hours)       Nap during the day       Night terrors

What time to bed? \_\_\_\_\_ Get up? \_\_\_\_\_

**DIET:**

Breast fed? *How long?* \_\_\_\_\_       Formula? *What kind? (please circle)* Dairy Soy Other

**FOOD INTRODUCTION:**

Age began solid foods? \_\_\_\_\_ What was introduced first? \_\_\_\_\_

Any reactions? \_\_\_\_\_

Any food allergies / intolerances? \_\_\_\_\_

Any special diet? ( i.e. vegetarian, religious etc.) \_\_\_\_\_

How are they eating now? \_\_\_\_\_

Favourite food? \_\_\_\_\_ Least favourite food? \_\_\_\_\_

*Please list foods eaten in a typical day:*

Breakfast: \_\_\_\_\_

Snack: \_\_\_\_\_

Lunch: \_\_\_\_\_

Snack: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snack: \_\_\_\_\_

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**BOWEL MOVEMENTS:**

How often does your child have a bowel movement? \_\_\_\_\_

Has your child ever had blood or mucous in his / her stool? \_\_\_\_\_

Do you see any undigested food in the stool? \_\_\_\_\_

Does your child have to strain to have a bowel movement? \_\_\_\_\_

**MEDICATIONS / SUPPLEMENTS:**

Please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL:**

Day Care                       Caregiver                       School      Grade? \_\_\_\_\_

What do they like best at school? \_\_\_\_\_

What don't they like? \_\_\_\_\_

What do they do well at? \_\_\_\_\_

Extracurricular activities? (*Please list*)

Thank you for taking the time to fill in this in-depth questionnaire.

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**CONSENT TO TREATMENT**

Naturopathic medicine is a unique approach to improving health and treating illness. Focusing on prevention, and using natural substances and treatments, Naturopathic Doctors support and stimulate the body's ability to heal itself. The methods used in this clinic for assessment include case history taking, physical examination and laboratory testing. Therapeutics include nutrition, homeopathy, botanical (herbal) medicine, physical medicine, hydrotherapy, detoxification techniques, acupuncture, hypnosis and lifestyle counseling.

Each person must sign this document before any treatment will be rendered.

My signature acknowledges that I have been informed and understand that:

(1) I am encouraged to create a comprehensive health care team working towards my best interests and continue to seek medical care from other health care practitioners qualified to practice in Ontario such as a physician, surgeon, dentist, chiropractor, etc., as required.

(2) I understand that Naturopathic Doctors are required by their licensing boards to perform a screening physical examination on each new patient. This will be adhered to unless a full report is sent by the referring practitioner and that report is accepted by the attending practitioner.

(3) I have received a full and complete explanation of the treatments or services that I may receive at this office and hereby authorize and consent to treatment.

(4) I understand that working with a Naturopathic Doctor involves a team-like approach and while I expect my Naturopathic Doctor to provide me with appropriate individualized advice as to how to attain my wellness goals, I also commit to being responsible for my own health. If I am having difficulty following a treatment plan that I have agreed to, I will contact my Naturopathic Doctor so that we can make whatever modifications are necessary for my lifestyle to ensure that I continue to work towards my goal of wellness at whatever pace we decide on together.

(5) I agree to pay my full account at the time of each visit or treatment, including fees for services and costs of supplements, reference materials and laboratory tests. I am aware that these fees are not covered by OHIP. In the event that an invoice is not paid in a timely manner, I understand that 2% per month interest will be added to any outstanding balances.

(6) I am aware that I can purchase the products recommended by my Naturopathic Doctor at the location of my choice. I am under no obligation to purchase products at M&Y Chiropractic Health & Wellness Centre.

(7) I understand that to provide me with Naturopathic goods and services, M&Y Chiropractic Health & Wellness Centre must collect and use some personal information about me as required by law and governing bodies. Any other use of any personal information will require my express written consent.

(8) I understand that payment is due at the requested appointment time. I understand that M&Y Chiropractic Health & Wellness Centre requires a minimum of 24 HOURS NOTICE of any appointment change or cancellation. If I do not give 24 hour notice or fail to appear for my requested appointment time, I agree to pay the full fee for my appointment. I understand that this time is reserved for me.      Initials \_\_\_\_\_

I, \_\_\_\_\_, have read, understood and acknowledge the above statements.

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Primary ND: \_\_\_\_\_ Date: \_\_\_\_\_