Blackfalds Chiropractic Centre
5007 Broadway Ave.
P.O. Box 1510,
Blackfalds, AB. T0M 0J0
Phone: 403-885-5808

Infant Health History

Date: _____

Child's Name: _____ Alberta Healthcare #:_____ Sex: ◯M ◯F

Address: _____ City: _____ Province: _____ Postal Code: _____

Email: _____Would you like Emailed? Receipts ◯No ◯Yes

Would you like reminders of your upcoming appointments by: ◯ Emailed ◯ Text (if text) Service Provider

Date of Birth: D/____ M/____ Y/_____ Weight: _____ Height: _____

Mother's name: _____ Cell #: _____ Work #: _____

Father's name: _____ Cell #: Work #:

Reason for child's visit: _____

Health History

Check any box that applies:

Childhood Diseases

☐ Measles	☐ Mumps	☐ Rubella	☐ Chicken Pox
☐ Whooping Cough	☐ Rubeola	☐ Colic	☐ Other: _____

Has this child ever suffered from:

☐ Asthma	☐ Ear Infections	☐ Hyperactivity	☐ Broken Bones
☐ Difficult Breathing	☐ Allergies	☐ Back/Neck Problems	☐ Arthritis
☐ Tuberculosis	☐ Dizziness	☐ Arm/Leg Problems	☐ Neuritis
☐ Cold/Flu	☐ Poor Appetite	☐ Headaches	☐ Diabetes
☐ Throat Infections	☐ Digestive Disorder	☐ "Growing" Pains	☐ Heart Trouble
☐ Convulsion	☐ Bed Wetting	☐ Hypertension	☐ Sinus Infections
☐ Paralysis	☐ Joint Problems	☐ Anemia	☐ Chronic Ear Aches
☐ Walking Problems	☐ Rheumatic Fever	☐ Cancer	

Fill in the following that apply

Surgery: _____ Medications: _____ Accidents: _____

Congenital anomalies / defects: _____

Immunization History: _____

Name of Pediatrician or General Practitioner: _____ Last visit: _____

Has your child been treated on an EMERGENCY basis? _____

Would you describe your child's health as: ☐ Very robust ☐ Very good ☐ Average ☐ Poor ☐ Sickly

Has there been a recent change in your child's energy level? If yes, is it ☐ Higher or ☐ Lower

Is there anything else that we should know that has not been addressed? _____

_____

Please turn over and complete the back of page

Labour and Delivery (to determine birth trauma)

1. Place of birth: _____

   Birth attendants: _____

2. Was there any difficulty with the labour and delivery? ◯Yes ◯ No

   First stage (approx. time): _____ Any problems, drugs given, intervention: _____

   _____

   Second Stage (approx. time): _____ Problems, etc: _____

   _____

   Third Stage (approx. time): _____ Problems, etc: _____

   _____

3. Baby's APGAR: _____

   _____

   Did the baby have any trouble to breathe? ◯Yes ◯No

   Baby's colour at birth: _____

   Did you get to hold the baby and keep the baby with you from the time of birth onwards? _____

   Was the baby given any medication or artificial feeding following the birth? _____

   Baby's weight at birth: _____ Length: _____

Newborn Period (complete for newborns only)

1. Is your baby being breastfed?◯Yes ◯ No

   Any feeding problems?◯Yes◯No If yes, please describe: _____

   Are there foods or liquids besides breast milk being given? _____

2. Any illnesses or problems since birth? _____

3. How would you describe your baby's disposition at this point? _____

   Any sleeping problems? _____

_____ _____

Date Parents Signature

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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a

Please Turn Over

damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____ Date: _____
Signature of patient (or legal guardian)

_____ Date: _____
Signature of Chiropractor