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

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

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT

Blackfalds Chiropractic Centre

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about 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. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____
Patient Name (print)

_____	_____	_____
Patient/Guardian Signature	Date	Chiropractor Signature

Updated: September 2025