Mama & Me Chiropractic – Cochrane AB
www.prenatalchiropracticcochrane.com
drgilliansawyer@gmail.com

Pediatric Patient Profile

Dear Parent:

Please complete this profile, the answers will help determine if Chiropractic can help your child.

Personal Information

Date: _____ Child's Name:_____

Parent 1 Name: _____ Parent 2 Name: _____

Alberta Health Care #:_____ Phone: _____

Address: _____Postal Code_____

Age: _____ Weight: _____ Height: _____

Birth date: _____ Birth Place: _____

School/daycare: _____ Family MD/Pediatrician: _____

Referred to this office by: _____

Current Health Condition

Purpose of appointment/current complaint:
_____

Previous treatment for this condition: _____

When did this condition begin: _____

Did a fall/injury/trauma contribute to the current complaint: _____

*Is this (circle): new/recurring

*Did it come on (circle): suddenly/gradually/comes & goes

Is your child presently taking and medication or under any other medical care:
_____

For what conditions:
_____
_____
_____

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Past Health History

Birth History:

Length of Pregnancy: full term (weeks) _____

Any issues during the pregnancy for mom/baby: (position of baby, blood pressure, etc);
_____

Location of birth: Home/Hospital/Birthing Center

Delivery: Vaginal/ Breech/ Cesarean/ Epidural/ Forceps/ Vacuum

Any Postpartum complications: _____

Length of labour: _____ Normal/difficult

Birth Weight: _____ Birth Length: _____ APGAR scores: _____

Any Congenital anomalies: _____

Infancy History:

Feeding: (circle) Breast/ Bottle/ Formula Latching well: Y/N Breast preference: Y/N/right/left

Sleep Quality: good/fair/poor Average hours total/night: _____ Hours in a row: _____

Trouble settling/ falling asleep: (circle) always/occasional/never

General Health History

Any known health conditions/allergies: _____

Illness/Falls/Injuries:_____

Hospitalizations/ Surgeries/ Stitches/ X-rays _____

Treatment for any health conditions in the past year : _____

Previous Chiropractic Care/Craniosacral : _____ Date: _____

Vaccination history_____

Last doctors/ pediatrician appointment:_____ any concerns: _____

Lifestyle

Activities: _____ Computer/desk time:_____ hours/day

Appetite/eating habits: good/fair/poor Toddler/childhood sleep quality: good/fair/poor

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Please **check** any of the following conditions that are **currently** a problem; and underline any that were a problem in the past:

MUSCLE & JOINT
sore muscles
sore joints
growing pains
muscle cramps
muscle jerking
back problems
neck problems
painful tailbone
pain between shoulders
spinal curvature
arthritis
difficulty chewing
clicking in jaw
general stiffness
walking problems
feet turn in/out
coordination problems
headaches
pain in ankles/knees/hips

GENERAL
fatigue
allergies
difficulty sleeping
Dizziness/fainting
earaches/infections
nose bleeds
sore throat/ frequent colds/flu
asthma
chronic cough
enlarged glands
loss of weight
poor exercise/appetite
nervousness
depression/confusion
Vision/dental/hearing problems
hyperactivity
behavioral problems
Epilepsy/seizures
rheumatic fever
stomach aches

INFANCY
Colic
tilting head to one side
difficulty nursing
preferred side nursing
slow weight gain
fussing in specific positions
Screaming/crying

ORGANS
bedwetting
constipation/diarrhea
anemia
Thyroid issues
vomiting
skin eruptions/eczema

OTHER CONCERNS:
_____
_____
_____

I have rights for this child and by signing below authorize chiropractic care for him/her.

Signature: _____ Date: _____

Print name: _____ *please also see informed consent

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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 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.

_____ Date: _____ 20____.

Name (Please Print)

_____ Date: _____ 20____.

Signature of patient (or legal guardian)

_____ Date: _____20____

Signature of Chiropractor