Rehab Connections
Injury & Chiropractic Wellness

Confidential Pediatric Patient Health Record

Today's Date (mm/dd/yyyy): ____/____/____

How did you hear about us? ☐ Family _____ ☐ Friend _____ ☐ TV ad _____ ☐ Drove by
☐ Close to home/work ☐ Dr. _____ ☐ Yellow pages, which one? _____ ☐ Newspaper _____ ☐ Hospital

Personal Information

Title: ☐ Mr. ☐ Ms. ☐ Mrs. Last: _____ **First:** _____ **File #:** _____
Birth Date (mm/dd/yyyy): ____/____/_____ **Age:**_____ **Sex: Male / Female**
Address: _____ **Apt #** _____
City: _____ **Province:** _____ **Postal Code:** _____
Home Phone: (_____) _____-_____ **Cell Phone:** (_____) _____-_____
Parent's Name: _____ **Parent's Work / Cell Phone:** _____

Emergency Contact

Name:_____ **Relationship: ☐ Father ☐ Mother ☐ Relative ☐ Other** _____
Home Phone: (_____) _____-_____ **Work / Cell Phone:** (_____) _____-_____

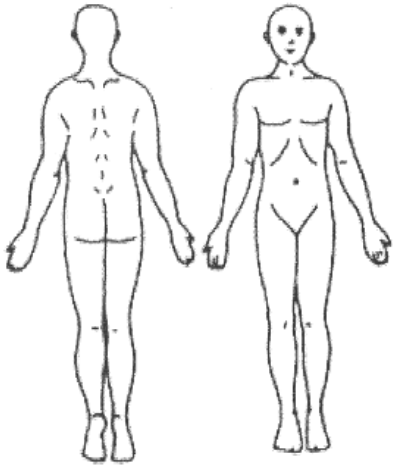
Current Health Condition

What brought you here today?:_____
_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT
→ → → → → → →

Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing



When did this Condition BEGIN (mm/dd/yyyy)? _____/_____/_____

Has it ever occurred before? ☐ Yes ☐ No. When? _____

Is the Condition: ☐ Auto Related ☐ Home Injury

☐ Slip or Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause ☐ Other

Explain: _____

Date of Accident: _____ **Time of Accident**: _____ **am /pm**

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us? _____

Previous Chiropractor: _____**Date of Last Visit:** ___ / ___ / ___ **Reason:** _____
Are you satisfied with the care your child has received there? _____ **N** _____ **Y**

Conditions your child has suffered from during the past six months:

☐Ear Infections	☐Scoliosis	☐Seizures	☐Chronic Colds	☐Headaches
☐Asthma/Allergies	☐Digestive Problems	☐ADHD	☐Recurring Fever	☐Growing/Back Pains
☐Colic	☐Bed Wetting	☐Car Accident	☐Temper Tantrums	☐Other _____

☐ # of doses of Antibiotics child has taken in 6 months: _____ lifetime: _____
☐ # of doses of other medications child has taken in 6 months: _____ lifetime: _____

Vaccination History: _____
_____

Patient Name: _____ **File #:**_____ **Today's Date (mm/dd/yyyy):**_____

Childhood Diseases:

Chicken Pox (Age:)	Rubeola (Age:)	Whooping Cough (Age:)	Mumps (Age:)	Rubella (Age:)

Prenatal History:

Name of Obstetrician/Midwife: _____		
Complications during pregnancy?	Ultrasounds during pregnancy?	#:
Medications during pregnancy/delivery?	Birth Intervention: ____ Forceps ____ Vacuum Extract	
Birth Location: ____ Hospital ____ Birthing Center ____ Home	Complications during delivery?	
Genetic Disorders or Disabilities?	Birth Weight: _____ Birth Length: _____ APGAR Scores: ____, ____	
Cigarette/Alcohol use during pregnancy?	Ceasarian Section: _____ Emergency _____ Planned	

Feeding History:

Breast Fed? mths	Formula Fed? mths	Solids: mths	Cow's Milk: mths	Food Allergies?

Developmental History: During the following times your child's spine is most vulnerable and should routinely be checked by a chiropractor for prevention and early detection of vertebral misalignment. At what age was your child able to:

Respond to sound:	Respond to visual stimuli:	Hold head up:	Sit Up:	Stand alone:	Cross Crawl:	Walk alone:

According to Scientific Research, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc) Was this the case with your child? _____ N _____ Y

What high impact or contact sports has your child participated (football, gymnastics, etc.):	
Dates your child has been in a car accident:	Dates your child been seen for an Emergency:
Other traumas not described above:	Prior Surgery:

We are here to serve you, and encourage you to ask questions. Your participation is vital and will help determine your results.

Financial Responsibility – Your financial commitment and time commitment to your recommended care will help to ensure progressive recovery and overall success in healing.

Financial Information:

Who Is Responsible For Your Bill? ☐ **Mother** ☐ **Father** ☐ **Both** ☐ **Other (be specific):**_____

Types Of Care (Relief – Corrective – Wellness)

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain and/or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying the floor that is getting wet from a leak, but not fixing the leak.

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

☐ **Relief Care** ☐ **Corrective Care** ☐ **Check here if you want the Doctor to select the type of care appropriate for your condition**

_____ _____ _____

Signature of Patient (or Guardian) **Print Name of Patient** **Date**

Informed Consent for Examination

Consent to Examination:

I hereby request and consent to a physical examination of my child by doctors and/or staff of Rehab Connections (1572292 Ontario Inc.). I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered to me will be immediately due and payable.

_____ _____ _____

Signature of Parent (or Guardian) **Print Name of Patient** **Date**

_____ _____ _____

Signature of Clinic Staff **Print Name of Clinic Staff** **Date**