TILLSONBURG
CHIROPRACTIC
AND WELLNESS

DR. FATIMA KORAH
10 Brock Street East, Tillsonburg ON N4G 1Z5
Phone: (226) 641-5155 • Fax: (226) 641-5156
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CONFIDENTIAL BABY-TODDLER (0 - 4 YEARS) HISTORY FORM

Please take a few moments to complete this form. Your answers will help us to determine if we can accept your case. If we sincerely believe that your condition will respond more favourably with another health care provider, we will be happy to refer you. If you need help with form, please do not hesitate to ask one of our Chiropractic Health Assistants.

Date:____________________

Personal Information

Name:__________________________________ Address:____

City: ___________________________________ Province:______________ Postal Code: _________________

Home Phone: ____________________________ Birth date:_____/_____/____(mm/dd/yy) ☐ Male ☐ Female ☐Undisclosed

Parents Occupation: ______________________ Business / Employer: _________________________________

Business Phone: _________________________ Extended Health Coverage: ___________________________

Mother & Father Names: ___________________ Siblings Names & Ages:______________________________

Mobile Phone:____________________________ Name of Emergency Contact:__________________________

Emergency Contact's Relationship: __________ Phone Number For Emergency Contact: __________________

Referred To This Office By: ☐Yellow Pages ☐Website ☐RMT ☐Patient/Dr. (name):___________________________

Email Address:___________________________

Please check the phrase that most represents your reason for child's care:

❑ Wellness ❑ Prevention ❑ Feel good ❑ Symptom Relief

Current Health Information

*If this child has **no complaints** and this exam is for a spinal wellness check-up, **please skip to section** on the next page marked with*

***PAST MEDICAL HISTORY**

Current complaint(s) ____

When did this condition begin? ______________________________ Has this occurred before? ❑ No ❑ Yes

What aggravates the child's condition(s)? ❑ Sitting ❑ Standing ❑ Bending ❑ Lifting
❑ Walking ❑ Sleeping ❑ Other ____________________________________

What relieves the child's condition? ❑ Ice ❑ Heat ❑ Massage ❑ Stretches ❑ Bed Rest ❑ Walking
❑ Medication ❑ Other ____

Is this condition becoming ❑ Worse ❑ Better ❑ Constant ❑ Comes & Goes

Have you seen other doctors/therapists seen for this condition? ❑ No ❑ Yes Who? ____________________________

How does this condition affect the Child's

❑ Ability to sleep ❑ Ability to Eat. ❑ Behaviour ❑ Ability to Play

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Past Medical History**

Name of this child's Medical Doctor/Town ______________________________

Date of last physical examination ______________________________

Does this child currently take any medications ❑ No ❑ Yes ______________________________

Does this child currently take any natural supplements ❑ No ❑ Multivitamins ❑ Other ______________

Is this child currently breastfeeding/ was the child previously breast fed? ❑ Yes ❑ No ❑ Formula

Has your child had any issues with-

❑ Feeding ❑ Indigestion/Constipation and gas ❑ Inconsolable crying and mood

❑ Back arching or seeming discomfort ❑ Favouring head turn to one side

If Yes- please elaborate ______________________________

____

What is your personal satisfaction with this child's diet?

❑ Highly Satisfied ❑ Satisfied ❑ Dissatisfied ❑ Highly Dissatisfied

Please rate the quality of this child's sleep: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

Number of sleeping hours at night: __________ Number of napping hours during the day:__________

Does this child suffer from any other health conditions? ❑ No ❑ Yes ______________________________

<u>History of Birth</u>

Birth Weight: ______________ Birth Length: ______________ Position at birth:________________

Arrival Time: ❑ Premature ❑ Term (40 weeks) ❑ Post Term- ______weeks

Any Intervention used: ❑ Forceps ❑ Vacuum Extraction. ❑ Manual Pulling by Doctor/Midwife ❑ Epidural

Type of Birth: ❑ Vaginal ❑ C Section

Duration of Labour: __________

Issues during pregnancy including: : ❑ Fall on buttocks ❑ Hypertension ❑ Gestational Diabetes ❑ Low Back pain

Apgar Scores (if Known) __________ __________

At birth, was there presence of Jaundice (yellow)____________________ OR Cyanosis (blue)____________________

<u>Milestones:</u>

At what age did your child:

Hold up head ____________________ Sit alone ____________________

Crawl ____________________ Stand ____________________

Walk alone ____________________

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Past History Traumas

Please note any Please note any injuries below- with the approximate year and any details.

Major traumas/falls: ____

Birth Injuries: ____

Surgeries: ____

Has this child ever been to a Chiropractor before? ❑ No ❑ Yes

Is there any family history of scoliosis? ❑ No ❑ Yes, please list relation _________________

Informed Consent to Examination & First Treatment.

As with any medical procedure your child undergoes, it is important to be fully informed about the type of procedure and the benefits and risks associated with that procedure.

By signing below, you are agreeing to have your child examined and treated by one of the Chiropractors at Tillsonburg Chiropractic and Wellness. The purpose of this examination is to determine the cause of any health problems that your child may be experiencing. The examination also allows the doctor named above to determine what the best course of treatment would be in your child's individual case. The examination may include but not be limited to postural assessment, range of motion testing of various areas of your child's spine and extremities, intra-oral exam, various orthopedic and neurological tests, and palpation of your child's joints and muscles using our hands. The chiropractic examination is a “hands-on” approach so that we can best assess your child's health. If a problematic area is identified during the exam it will be communicated with the caregiver and typically treatment will be applied immediately with oral consent from the caregiver to help avoid prolonging the appointment for the little one. At the second visit we will go through full details and an additional consent with the caregiver and explain the proper plan of management and recommendations depending on the unique case.

Office Policies *Please Initial Below*

______I agree to the DC's discussing with other health practitioners at Tillsonburg Chiropractic and Wellness health concerns related to my chief complaint.

______I agree to DC's releasing proof of attendance and payment information to 3rd party benefit and insurance companies.

____

Baby/Toddler's Name

_________________________	_________________________	_______________
Parent Name	Parent Signature	Date
_________________________	_________________________	_______________
Witness Name	Witness Signature	Date