Child Health History – 15 years and under

Child's Name _____ **Date of Birth (** mm **/** dd **/** yyyy **)**

Preferred Name (if different from above) _____ **Pronouns** _____

Parent/Guardian Names _____

Main Phone # _____**Email:** _____

Full Address _____

Emergency Contact: Name/Phone # _____Relationship_____

Primary Care Physician: _____Phone (if known)_____

Clinic Name _____ Last Physical Exam **(** mm **/** dd **/** yyyy **)**

Findings (if any) _____

Has your child had x-rays in the last **2 years**? If yes, what part of the body? _____

Are you seeking treatment associated with an insurance claim? ☐ Yes ☐ No

Are you currently seeing any other complementary healthcare providers:

☐ Acupuncturist ☐ Chiropractor ☐ Massage Therapist ☐ Naturopath ☐ Osteopathic Manual Therapist
☐ Physiotherapist ☐ Other_____

An accurate health history is important to ensure it is safe to receive treatment. If your health status changes in the future, please inform your practitioner. All information gathered is confidential except as required by law. You will be asked to provide written authorization for release of any information.

Please indicate areas of concern and treatment goals:

_____

_____

Have they sustained any significant physical injuries, surgeries, or other medical procedures? Include the nature and approximate date (or age).

_____

_____

Please list any allergies or sensitivities:

_____

_____

Are they currently or regularly taking any medications? (Including over the counter, supplements, prescribed or un-prescribed drugs)

_____

_____

When did the pain or problem start? _____

Does the feeling radiate and where? _____

Please check all that apply to pain.

☐	Achy	☐	Burning	☐	Gripping	☐	Numb	☐	Sharp	☐	Dull	☐	Sore	☐	Weak	☐	Stabbing
☐	Shooting	☐	Throbbing	☐	Tingling	☐	Loss of sensation	☐	Other:								

What is the frequency of the pain/altered sensation that you have described above?

☐ Constant ☐ Daily ☐ Weekly ☐ Interferes with sleep

What time of day is the sensation worse? ☐ AM ☐ PM

Grade the sensation _____/10

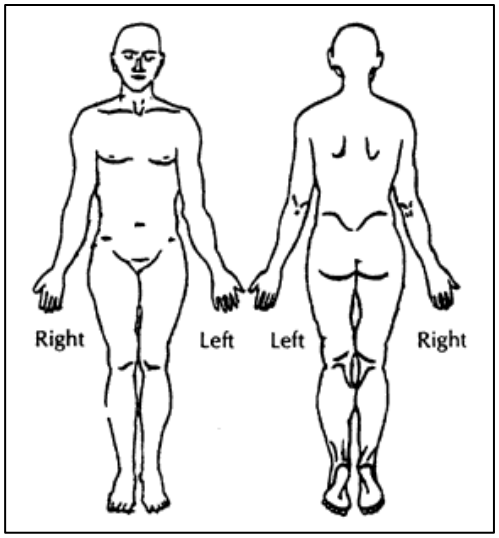
What relieves the condition? _____

What aggravates the condition? _____

Have you tried anything else to alleviate the condition? _____

_____

Please circle areas of concern.



Soft tissue and joint issues (please check all that apply)

☐	Cramps	☐	Swelling	☐	Joint disease	☐	Tendonitis	☐	Whiplash	☐	Spasms	☐	Scoliosis	☐	Sprains
☐	Other:														

Respiratory Issues (please check all that apply)

☐	Asthma	☐	Bronchitis	☐	Difficulties breathing	☐	Chronic cough	☐	Chronic congestion	☐	Sinusitis
☐	Other:										

Skin Issues (please check all that apply)

☐	Allergies	☐	Bruise easily	☐	Cold sores	☐	Dry skin	☐	Eczema	☐	Psoriasis	☐	Rash	☐	Sensitivities
☐	Warts	☐	Other:												

Gastrointestinal (please check all that apply)

☐	Acid reflux	☐	Colitis	☐	Constipation	☐	Crohn's	☐	Diarrhea	☐	Gallbladder	☐	GERD	☐	Hiatus hernia
☐	IBS	☐	Indigestion	☐	Nausea	☐	Ulcer	☐	Other:						

Cardiovascular (please check all that apply)

☐	Edema	☐	Heart condition	☐	Heart failure	☐	Hemophilia	☐	Low or High blood pressure	☐	Poor circulation
☐	Other:										

On a scale of 1 (poor) to 5 (good) rate each category for each age group.

	0 to 6 mo	6 to 12 mo	1 to 5 yrs	5 to 10 yrs	Please describe the problem or issue (if any)
Eating habits					
Sleeping habits					
Bowel movements					
Urination					

Does the child wear: glasses / contact lenses / hearing aids / other_____

Are the child's immunizations up to date? ☐ Yes ☐ No

Does your child have any other conditions or concerns that are not listed? ☐ Yes ☐ No

Please Describe: _____

Mother's Pregnancy History

List any injuries, illnesses, and medication's during pregnancy:

_____

_____

☐ **Vaginal delivery** ☐ **C-Section:** ☐ **Emergency** ☐ **Scheduled**

List any complications in labor, instruments used, medications used:

_____

_____

Post-Partum: ☐ Jaundice ☐ Colic ☐ Latching & feeding difficulties ☐ Sleeping difficulties

Other: _____

Waiver of Responsibility

I understand that treatments are not a replacement for care provided by a medical doctor or mental health professional.

I (the parent/guardian) am aware that treatments may include but are not limited to: Osteopathic Manual Therapy, Massage, CranioSacral Therapy, Acupuncture, Acupressure, Cupping, Gua Sha, Reiki, PSYCH-K®, exercise, the use of electrical modalities.

I (the parent/guardian) understand the therapist is open to any questions throughout the treatment and that they believe in any open discussion concerning the effects and procedures of therapy. I will inform the practitioner of any specific issues related to being touched. I (the parent/guardian) understand that I will be asked for additional consent for some specific techniques, if we have decided that those treatments will be beneficial to my child's wellbeing, and if I am comfortable doing so.

I (the parent/guardian) consent to treatment and have provided a complete and accurate health history. I understand that this form will remain valid, and in effect for the duration of my child's care.

I (the parent/guardian) authorize the clinic and its associated health professionals to collect my child's personal and medical information as documented above. I understand that my child's personal and medical information is confidential and will only be disclosed to third parties with my written permission.

Please Note:
Payment is due at time of treatment. We do not direct bill. Treatments are not covered by Alberta Health Care but may be covered by private insurance. Missed appointments will be billed at the full rate unless 24 hours' notice is provided. Please be aware that insurance companies do not reimburse for missed appointments.

We would like to kindly remind you that people may have allergies or sensitivities to fragrances. Please refrain from using scented products such as perfumes, colognes, and lotions when visiting the clinic. Thank you for your cooperation.

Child's Name: _____

Parent's/Guardian's Name (please print): _____

Signature _____ Date: **(mm / dd / yyyy)**