Child/Infant Health History Form

Child's Name _____Today's Date_____

Parent's/Guardian's Names _____

Street Address_____

City _____ Prov. _____ Postal Code _____

Phone (hm): _____(wk):_____(cell)_____

E-mail address _____Child's D.O.B_____

Primary Care Physician: Name_____Phone_____
Clinic name / address_____
Last Physical Exam_____ Findings_____
Has the child had x-rays in the last 2 years? If yes, what part of the body?
_____

Present Involvement in other complimentary health care. (please check all that apply)

_____ Osteopathic Manual Therapist _____ Acupuncturist _____ Massage Therapist
_____ Physiotherapist _____ Chiropractor _____ Naturopath _____Other (please list)

_____

Please note:
An accurate health history is important to ensure that it is safe for you to receive treatment, for your practitioner to provide treatment to you, as well to maintain the safety of other patients in the office. If your health status changes in the future, please inform your practitioner. All information gathered for this treatment is confidential except as required by law or except to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information.

Please indicate areas of concern and your treatment goals:

_____
_____

Mother's Pregnancy History: (List any injuries, illnesses, medication's during pregnancy)

_____
_____
_____

Delivery: (pre-term, full term, post term, list any complications in labor, instruments used, natural birth, medications used, C-Section- emergency or scheduled)

_____
_____
_____
_____

Post Partum: (APGAR score, jaundice, colic, latching & feeding difficulties, sleeping difficulties, allergies/ sensitivities)

_____
_____
_____

Child/Infant Health History Form

0-6 months please list:(eating & sleeping habits, bowel & urine movements and any gastrointestinal problems, injuries, soft tissue/joint issues, respiratory issues, skin issues, cardiovascular problems, illnesses/diseases, immunizations, medications, allergies/sensitivities)

_____
_____
_____
_____

6-12 months please list:(eating & sleeping habits, bowel & urine movements and any gastrointestinal problems, injuries, soft tissue/joint issues, respiratory issues, skin issues, cardiovascular problems, illnesses/diseases, immunizations, medications, allergies/sensitivities)

_____
_____
_____
_____

1-5 years please list:(eating & sleeping habits, bowel & urine movements and any gastrointestinal problems, injuries, soft tissue/joint issues, respiratory issues, skin issues, cardiovascular problems, illnesses/diseases, immunizations, medications, allergies/sensitivities)

_____
_____
_____
_____

5-10 years please list:(eating & sleeping habits, bowel & urine movements and any gastrointestinal problems, injuries, soft tissue/joint issues, respiratory issues, skin issues, cardiovascular problems, illnesses/diseases, immunizations, medications, allergies/sensitivities)

_____
_____
_____
_____

Please list a brief family history pertaining to health related issues. (e.g. diabetes, cancer, heart disease, allergies)

_____
_____
_____
_____

Does your child wear glasses/ contact lenses/ hearing aid/ other?_____
_____

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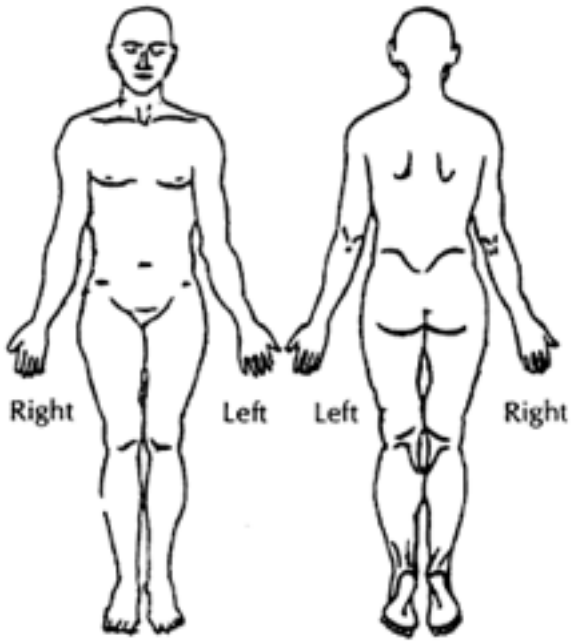
Please check all that apply relating to pain (presently and in the past):

Nature of pain or altered sensation: _____ Achy _____ Dull_____ Burning _____ Gripping _____Sharp _____Sore_____ Throbbing_____ Weak_____ Numb_____ Shooting_____ Stabbing ____ Tingling _____Loss of sensation Other _____

Frequency of pain or altered sensation: _____ Constant _____ Weekly_____Daily _____ Monthly _____ Chronic_____ Acute_____ Interferes with sleep

When did the pain/problem start? _____
Does the feeling radiate? Where? _____
Grade the sensation /10 What time of day is the sensation worst? _____ AM _____ PM
What relieves your condition?
_____
What aggravates the condition?
_____
Have you tried anything else to relieve the condition? (list)
_____
_____
Has this condition occurred before? Under what circumstances?
_____
_____

Please circle areas of concern on the image below.



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Waiver of Responsibility

I am aware that my treatments may include, but is not limited to, one or more of the following: Osteopathic Manual Therapy, Massage, CranioSacral Therapy, Acupuncture, Acupressure, Cupping, Gua Sha, BodyTalk Therapy, Reiki, PSYCH-K®, the manipulation of soft tissue and joints of the body, exercise, the use of electrical modalities, in order to improve or maintain my physical functions and reduce or eliminate pain.

I understand that my therapist is open to any questions throughout the treatment and that he/she believes in an open dialogue of discussion concerning the effects and procedures of therapy. I will inform him/her of any particular areas that I am uncomfortable having massaged, including specific issues related to being touched. I 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 well being, and if I am comfortable doing so.

I consent to the 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 care.

Please Note:
Payment is due at time of treatment.
The therapy 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.

Child's Name _____

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

Signature of Parent/Guardian _____ Date_____

We would like to kindly remind you to be aware that there are clients in our office who may have allergies or sensitivities to certain scents. Please be courteous when using scented products such as perfumes, colognes, and lotions. Thank you for your cooperation.