

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 _____

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)

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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? _____

Child/Infant Health History Form

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

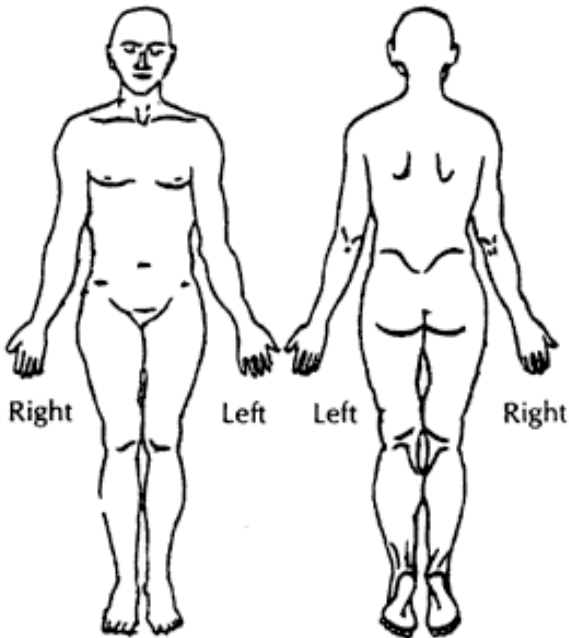
What relieves your condition?

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

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.

We do not direct bill.

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.

St. Albert Acupuncture & Wellness Inc.
Acupuncture, Athletic Therapy, NAET Allergy Elimination, Osteopathic Manual Therapy,
Massage Therapy, CranioSacral Therapy