Active Chiropractic Family Health Centre

Office Use Only			
☐ MB		☐ Ref.	
☐ Rel.		☐ FV	
☐ IFS		☐ Wel.	
☐ Update			

Pediatric Physiotherapy Health History Form
(0-10 yrs old)

For Your Information:
An accurate health history is important to ensure that it is safe for you to receive a chiropractic treatment. **If your health status changes in the future, please let us know**. **Please notify the front desk if you have moved or if any of your personal information changes, as this affects your receipt for insurance submissions**. All the information gathered for this treatment is confidential, except as required or allowed by law, or to facilitate assessment or treatment by any Physiotherapist at Active Chiropractic Family Health Centre. You will be asked to provide written authorization for release of any information. All payments are due prior to service. If you are covered by insurance, and your insurance does not cover any or part of a service you have received, you are liable for this fee.
Each therapist at Active Chiropractic requires 24 hours notice to cancel or reschedule an appointment as we often have a waitlist for acute patients. Failure to do so will result in the full treatment fee being charged (please see our current fee schedule).
If you are covered by insurance:
Please note that you are liable for this cancellation fee and it will not be reimbursed by your insurance carrier. ..... Initials _____

I have read and I acknowledge any and all costs associated with my appointments. ..... Initials _____
Did you know that you can book your appointments online 24 hrs a day 7 days a week? **Ask us how**!

Child's Name:		**Date:** DD/MM/YYYY
Child's Address:		**City:**
Email Address of Guardian:		**Postal Code:**
Courtesy reminder calls and emails: **Phone Call Reminders Y N** **Email Reminders Y N**		
Date of Birth: DD/MM/YYYY **Age:**	**Home Phone #:**	**Male Female**

Who referred you to Active Chiropractic?

Parent/Guardian Information:

	Emergency Contact:	***ER Number:***	***ER Relationship:***
	Parent/Guardian #1	Parent/Guardian #2	
Parent/Guardian Name(s)			
Parent/Guardian Work Phone			
Parent/Guardian Cell Phone			
Parent/Guardian Email			

Pregnancy
Duration: _____
Maternal Weight gain: _____
Maternal Exercise: _____
Diagnostic techniques: _____
Problems: _____

Labour
Length of time: Labour_____ Delivery_____
Where: ☐ Hospital ☐ Home ☐ Birthing Center ☐ Other
Type of Birth: ☐ Vaginal ☐ C-section
Interventions: ☐ Forceps ☐ Vacuum Extraction ☐ none
How initiated: ☐ Spontaneous ☐ Induced

Sedation or Anesthesia _____
Complications _____
Neonatal Period
APGAR Scores_____
Resuscitation required ☐ **Yes** ☐ **No** **Any presence of** ☐ **jaundice** ☐ **cyanosis**
Congentital anomalies/defects_____

Primary Care Physician (Name/Address/Phone)

Current Medication(s) and condition it treats:

Are you currently receiving treatment from another health care professional? YES or NO
If yes, for what?

Pediatric Patient Case History

Active Chiropractic Family Health Centre

Infant History:

Feeding: □Breast □Bottle □formula _____

□Difficulties_____

Sleeping Hours per night_____ Quality of Sleep: □ good □fair □poor

Bowel and Bladder_____

Developmental History: Age at which the child;

Responded to sound_____ **Followed object with eyes**_____ **Hold head up**_____

Sit alone_____ **Crawl**_____ **Stand**_____

Cruise_____ **Walk alone**_____

Childhood Diseases:

□Chicken pox □Mumps □Measles □Rubella □Whooping Cough □Other_____

Immunization Status:

_____

_____

Have you ever been hospitalized? Yes or NO **If yes, Nature/Date(s):**
Have you ever had surgery (besides birth)? YES or NO **If yes, Nature/Date(s):**
Other injuries: YES or NO **If yes Nature/Date(s):**
Do you have internal pins, wires, artificial joints, or special equipment? YES or NO **If yeds, What?/Where?**

Has your child ever suffered from:

□dizziness	□backaches	□hypertension	□muscle jerking	□diabetes
□tuberculosis	□joint problems	□allergies	□blood disorder	□headaches
□asthma	□neck problems	□anemia	□chronic earaches	□sinus trouble
□constipation	□arm problems	□hyperactivity	□arthritis	□diarrhea
□poor appetitie	□orthopedic problems	□heart trouble	□digestive problems	□bed wetting
□convulsions	□paralysis	□cold/flu	□behavioural	□walking problems
□broken bones	□ruptures/hernia	□rhumatic fever	□fainting	□leg problems
□growing pains	□joint problems	□stomach aches	□other_____	

Present History:

_____

_____

_____

Family History: □cancer □cardiovascular □diabetes □other_____

I have read the above information and have stated all my previous medical conditions. **I take it upon myself to update the Physiotherapist regarding any changes in my condition**. I understand that all physiotherapy treatments will be discussed and planned with the Physiotherapist, and will require my informed consent.

Furthermore, I authorize that the Physiotherapists providing care at Active Chiropractic Family Health Centre have full access to my client file.

Guardian Signature: _____ Date:_____

I consent to the sharing of my health history information, imagining and reports to the following practitioners of Active Chiropractic Family Health Centre: ____ Physiotherapist ____ Chiropractor(s) _____ Registered Massage Therapist(s) _____Naturopath(s) _____Fitness Trainer(s)

_____ _____

Signature **Date**

Active Chiropractic Family Health Centre

CONSENT TO PHYSIOTHERAPY

When you attend Physiotherapy, you may be assessed and treated with hands on techniques including soft tissue and joint mobilizations. Treatment may also include stretching and strengthening exercises, and education on proper body mechanics and posture. Please make sure that you discuss with the physiotherapist if you have questions or concerns about any of the assessment or treatment procedures that may be carried out. You may withdraw consent for any procedure at any time by informing the physiotherapist. By signing below, you agree that you understand and consent to treatment. You may inform the physiotherapist at anytime if that consent changes.

I, _____, consent to physiotherapy assessment and treatment by Active
Patient (full name, printed)

Chiropractic's Physiotherapist.

- ☐ _____ Colleen Bourgeois, PT
- ☐ _____

_____ _____
Patient Signature (or Legal Guardian) Signature of Physiotherapist

Dated this _____ day of _____, 20 _____

Active Chiropractic
Family Health Centre

Under the Canada Anti-Spam Legislation (CASL), effective as of July 1, 2014, we require your consent in order to send you electronic communications; for example, the latest in exercises, nutrition information, class schedules, appointment reminders and any other information that may be of interest to you. To allow us to continue providing information that is relevant to you, please take a moment and check the boxes for the information that you would like to receive.

Active Chiropractic would not want you to miss out on any information that is beneficial to you.

First Name: _____

Last Name: _____

Email address: _____

	Appointment Reminders/Confirmation If you circled 'Yes' on the first page to receive appointment reminder emails please check the box		
	Clinic Newsletter		Massage Therapy
	Physiotherapy		Kinesiology - News
	Chiropractic-News		Personal Training
	Bootcamp		Nutrition Counselling
	Yoga		Naturopath Medicine
	Concussion Management		Counselling
	Running Clinics		
	I do NOT wish to receive ANY emails		

You may withdraw your consent or modify your subscription preferences at any time.

Dated this_____ day of_____, 20_____.

_____ _____

Signature **Name – please print**

_____ _____

Witness - Signature **Name – please print**