Optimum Family
CHIROPRACTIC INC.

PERSONAL INFORMATION

Name: ____Preferred Name: ___________________Date: ________________
Birthday (MM/DD/YR): ________________________Age: ________Gender: M or F
Address: ____
City / Prov. / Postal Code: ____
Parents Names: ____
Home #: ____________________________Cell #: __________________________________Work #: ________________
E-Mail Address: ____
Would you like to receive e-mail appointment reminders? [ ] Day Of The Appointment [ ] 1 Day Before
Siblings Name(s) and Ages: ____

CHIROPRACTIC HISTORY

Have you been to a chiropractor before? ____ Yes ____ No Date of last visit:______________
Name of last chiropractor:____
Reason for seeing them:____
Describe your experience?____
How frequently did you go for adjustments?____
What made you decide not to return to see them?____
Who may we thank for referring you to our office? /or/ How did you choose us?

_Family/ Friend (name)______________________ _Workshop (which group)___________________
_Farmer's Market _Walk-in
_Health Care Provider________________________ _Print Advertisement________________________
_Website _Other______________________________________

HEALTH HISTORY

Name of Obstetrician / Midwife_____________________ Name of Pediatrician/Family MD ____________________
Date of last visit to MD ________________ Purpose of visit ____________________________________

PREGNANCY

Trauma/ illness during pregnancy ____
During the pregnancy did the mother:
Smoke? __Yes __No How much? _______________________________________
Drink? __Yes __No How much? _______________________________________
Were any supplements taken during the pregnancy? __Yes __No ______________________
Were any drugs taken during the pregnancy? __Yes __No ______________________
Any ultrasounds or other radiation? __Yes __No
If so, How many and for what reasons?____
Were there any invasive procedures during the pregnancy (amniocentesis, CVS etc.)? Yes No
Please explain ____

LABOUR

Position During Labour: __On back __ Side __Sitting __Standing
Was Labour Induced? __YES __NO
Did the Mother Have an Episiotopmy? __YES __NO
Was Monitoring Used? __Internal __External
Did You Receive Drugs? __Epidural __Morphine __Other _________________________

BIRTH

Location of birth? __ Home __Hospital __Birthing center

Birth Assistants? __ Midwife __Doula __ Medical Doctor __None

Was there any assistance needed during birth?

__ Forceps __ Cesarean __ Vacuum extraction

Were there complications during birth? __Yes __No

Please explain:____

Birth weight ____________________ Birth length ____________________

Was there any evidence of birth trauma to the infant? Check all that apply:

_Bruising _Fast or excessively long birth

_Odd shaped head _Respiratory depression

_Stuck in birth canal _Cord around neck

Congenital anomalies/ defects present? _______________________________________

VACCINATION HISTORY

What vaccinations were given and at what age?

____

Did you notice any negative reactions? __Yes __No ______________________________

Reason for vaccinations ____

GROWTH AND DEVELOPMENT

Any falls from couches, beds, change tables, etc...? __YES __NO ____________________

Any hospitalizations or surgeries? __YES __NO ____________________

History of antibiotics? __YES __NO ____________________

Was child breast fed? __YES __NO For how long? __________

Difficulties with lactation: __YES __NO ____________________

Quality of Sleep: __Good __Fair __Poor Number of hours ______________

Was Formula introduced? __YES __NO If so, at what age? _______

Was cows milk introduced? __YES __NO If so, at what age? _______

Have solid foods been introduced? __YES __NO If so, at what age?____Type of food __________

Food/juice intolerance? ____

Behavior problems? __YES __NO ____

Age when your child began daycare? ____

Any sports played? __YES __NO Which ones? ____________________ At what age? _______

Your Informed Consent

Chiropractic care has been proven to be safe, both clinically and scientifically for children of all ages. The risk of injuries and complication is so small that Chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Although Chiropractic is reported to be the safest health care system in the world, there are a few “side effects” associated with it and we feel that it is responsible to let you know:

A. Research shows that the most common unpleasant effect following chiropractic care is temporary muscle soreness associated with the adaptive changes after the adjustment. This however is only temporary and generally not severe soreness.

B. While extremely rare, there have been reports of ligament sprains and rib fractures.

I have read and understand the above consent. If I have any questions or concerns, I will discuss them with my Chiropractor.

I understand that research is an important aspect for all health care disciplines. For this reason, I consent to my information being used for reseach data purposes. (Your full name will not be used).

I consent to the care recommended by my Chiropractor and extend this consent to include all other Chiropractors in this office.

Child’s name:______________________________ Parent/ Guardian:____________________________

Signature: ______________________________ Witness:______________________ Date:_______