Child Health History Form (12 years old and under)

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.

CHILD'S NAME:	CHILD'S DATE OF BIRTH:(mm / dd / yyyy)
PREFERRED NAME (if different from above):	PRONOUNS:
PARENT / GUARDIAN NAMES:	
FULL ADDRESS:	
MAIN PHONE #:	EMAIL ADDRESS:
EMERGENCT 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 OR OTHER IMAGING IN THE LAST 2 YEARS?	
IF YES, WHAT PART OF THE BODY?	

Are you seeking treatment associated with an insurance claim?	▫ **Yes** ▫ **No**
If yes, please specify:	

Are they currently seeing any other complementary healthcare providers?						▫ **Yes** ▫ **No**
Acupuncturist	▢	Massage Therapist	▢	Osteopathic Manual Therapist	▢	Other:
Chiropractor	▢	Naturopath	▢	Physiotherapist	▢	

Please indicate areas of concern and treatment goals.

Have they sustained any significant physical injuries, surgeries, or other medical procedures? If yes please describe with approximate dates.

Please list any allergies or sensitivities.

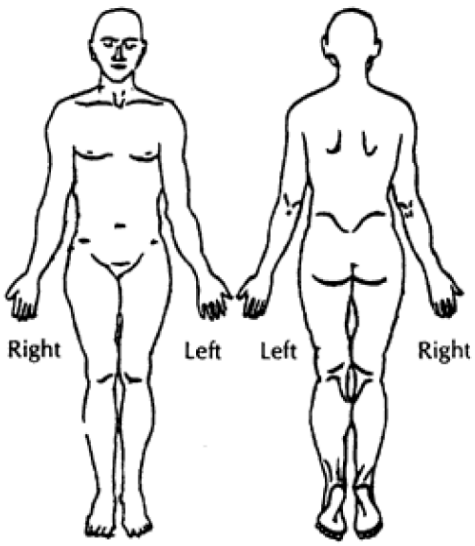
Are they currently taking any medications including over the counter, prescribed or unprescribed drugs, herbs, vitamins?

Do they wear or have:							
Glasses/Contacts	☐	Hearing aids	☐	Pins/Plates/Screws	☐	Other:	☐

In relation to pain / musculoskeletal conditions:	
When did the pain or problem start?	
Does the feeling radiate and where?	
What is the frequency? ☐ Constant ☐ Daily ☐ Weekly ☐ Interferes with sleep	
What time of day is the worse? ☐ AM ☐ PM	Grade the sensation: _____ / 10
What relieves the sensation?	What aggravates the sensation?

Please check all that apply relating to pain, and circle areas of concern on the figure to the right.

Achy	☐	Shooting	☐
Burning	☐	Sore	☐
Gripping	☐	Throbbing	☐
Numb	☐	Weakness	☐
Sharp	☐	Change in sensation	☐



Soft tissue and joint issues: (please check all that apply)			
Cramps/Spasm	☐	Scoliosis	☐
Bursitis	☐	Sprains/Strains	☐
Inflammation	☐	Swelling	☐
Paralysis	☐	Whiplash	☐
Sciatica	☐	Other:	☐

Respiratory conditions: (please check all that apply)							
Asthma	☐	Chronic congestion	☐	Chronic sinusitis	☐	Shortness of breath	☐
Bronchitis	☐	Chronic cough	☐	Cough with phlegm	☐	Other:	

Skin conditions: (please check all that apply)									
Acne	☐	Bruise easily	☐	Eczema	☐	Psoriasis	☐	Warts	☐
Allergies/Hives	☐	Dry/Itchy skin	☐	Fungal infections	☐	Rashes	☐	Other:	☐

Gastrointestinal conditions: (please check all that apply)									
Acid reflux/Indigestion	☐	Colitis	☐	Crohn's	☐	Gallbladder	☐	IBS	☐
Bloating/Gas	☐	Constipation	☐	Diarrhea	☐	GERD	☐	Nausea/ Vomiting	☐

Cardiovascular conditions: (please check all that apply)								
Blood clots	☐	Heart condition	☐	Low/High blood pressure	☐	Palpitations	☐	Other:

For each category below, please describe any problems or issues your child has now or has had in the past.
Eating habits:
Sleeping habits:
Bowel movements:
Urination:

Are their immunizations up to date?	☐ **Yes** ☐ **No**

Do they have any other medical conditions not listed here?	☐ **Yes** ☐ **No**
If yes, please specify:	

Describe any concerns you have regarding their comfort and safety during an acupuncture treatment, such as: needle phobia, bleeding disorders, infections, immunocompromised etc.

Mother's pregnancy history:							
Vaginal delivery	☐	C-Section	☐	Emergency delivery	☐	Scheduled delivery	☐
List any injuries, illnesses, and medication's during pregnancy:							
Other:							

Post-Partum:							
Jaundice	☐	Colic	☐	Latching/feeding difficulties	☐	Sleeping difficulties	☐
Other:							

Please confirm that you have read and understand each statement by initialling next to it.

Initials

☐ **Cancelling your appointment.**

We require a 24-hour notice when cancelling or rebooking appointments, this allows other clients to possibly receive care in your place. If an appointment is missed or cancelled within 24 hours, you may be billed.

☐ **We do not direct bill.**

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

☐ **Conduct in the clinic.**

Our clinic is a healing environment. As such, we ask that cell phones and other devices are silenced while in the clinic. We would like to kindly remind you that some people may have allergies or sensitivities to fragrances. Please refrain from using scented products such as perfumes, colognes, and lotions when visiting the clinic.

WAIVER OF RESPONSIBILITY

Initials

☐ I (the parent/guardian) 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, 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 an open discussion concerning the effects and procedures of therapy. I (the parent/guardian) 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 written permission.

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

Parent/Guardian Signature : _____ Date: (mm / dd / yyyy)