TILLSONBURG CHIROPRACTIC AND WELLNESS

DR. FATIMA KORAH
10 Brock Street East, Tillsonburg ON N4G 1Z5
Phone: (226) 641-5155 • Fax: (226) 641-5156
Email: tburg.chiro.clinic@gmail.com

CONFIDENTIAL CHILD (5-13 YEARS) HISTORY FORM

Date _____

Personal Information

Name: _____ Address: _____

City: _____ Province: _____ Postal Code:

Home Phone: _____ Birth date: ____/____/____ (mm/dd/yy)

❑ Male ❑ Female ❑ Undisclosed Parents Occupation: _____

Business / Employer: _____ Business Phone: _____

Extended Health Coverage: _____

Mother & Father Names: _____ Siblings Names & Ages: _____

Mobile Phone: _____ Name of Emergency Contact: _____

Emergency Contact's Relationship: _____ Phone Number For Emergency Contact: _____

Referred To This Office By: ❑ Yellow Pages ❑ Website ❑ RMT

❑ Patient/Dr. (name): _____ Email Address: _____

Please check the phrase that most represents your reason for care:

❑ Wellness ❑ Prevention ❑ Feel good ❑ Symptom Relief

Current Complaint

*If this child has **no complaints** and this exam is for a spinal wellness check-up, **please skip to * Past Medical history** on next page*

Current complaint(s)

_____

When did this condition begin? _____ Has this occurred before? ❑ No ❑ Yes

What aggravates the child's condition(s)? ❑ Sitting ❑ Standing ❑ Bending ❑ Lifting

❑ Walking ❑ Sleeping ❑ Other _____

What relieves the child's condition? ❑ Ice ❑ Heat ❑ Massage ❑ Stretches

❑ Bed Rest ❑ Walking ❑ Medication

❑ Other _____

Is this condition becoming ❑ Worse ❑ Better ❑ Constant ❑ Comes & Goes

Have you seen other doctors/therapists seen for this condition? ❑ No ❑ Yes Who? _____

How does this condition affect the Child's

❑ Ability to sleep ❑ Ability to Eat ❑ Behaviour ❑ Ability to Play

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*Past Medical History

Name of this child's Medical Doctor/Town _____

Date of last visit/examination _____

Does this child currently take any medications ❑ No ❑ Yes _____

Does this child currently take any natural supplements ❑ No ❑ Multivitamins ❑ Other _____

What is your personal satisfaction with this child's diet?
❑ Highly Satisfied ❑ Satisfied ❑ Dissatisfied ❑ Highly Dissatisfied Why? _____

Please rate the quality of this child's sleep: ❑ Poor ❑ Fair ❑ Good # of sleeping hours at night: _____

Does this child suffer from any health conditions? ❑ No ❑ Yes _____

Did your child have any delays in meeting developmental milestones? For example; Holding up head, walking, crawling etc.
If so please list: _____

Has this child ever had any x-rays taken? ❑ No ❑ Yes Of what area(s)? _____

Past Injuries/ Traumas

Any Major traumas/falls: _____
Birth Injuries: _____
Surgeries: _____

Current Fitness & Activity Level

❑ poor ❑ moderate ❑ great Sports/Activities: _____

Family Health History

Is there a family history of any of the following conditions?
☐ **Scoliosis** ☐ Allergies ☐ Heart Disease ☐ Arthritis ☐ Osteoporosis ☐ Cancer
☐ Diabetes ☐ Other _____

Please check if this child has had any of the following:

Musculoskeletal
☐ Low back pain
☐ Pain between shoulders
☐ Neck pain
☐ Headaches
☐ Arm pain
☐ Leg pain
☐ Jaw pain/clicking
☐ Growing Pains
☐ Scoliosis

Cardiovascular/Respiratory
☐ shortness of breath
☐ irregular heartbeat
☐ heart problems
☐ pneumonia
☐ bronchitis
☐ asthma

Gastro-Intestinal
☐ Poor appetite
☐ excessive thirst
☐ frequent nausea
☐ diarrhea
☐ constipation/gas
☐ bed wetting
☐ abdominal cramps
☐ heartburn
☐ Reflux

General
☐ fatigue
☐ high stress
☐ allergies
☐ poor sleep
☐ poor balance
☐ poor concentration
☐ recurring ear infections
☐ fainting

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Informed Consent to Examination

As with any medical procedure your child undergoes, it is important to be fully informed about the type of procedure and the benefits and risks associated with that procedure.

By signing below, you are agreeing to have your child examined by Dr. Fatima Korah at Tillsonburg Chiropractic and Wellness. The purpose of this examination is to determine the cause of any health problems that your child may be experiencing. The examination also allows the doctor named above to determine what the best course of treatment would be in your child's individual case. The examination may include but not be limited to postural assessment, range of motion testing of various areas of your child's spine and extremities, intra-oral exam, various orthopedic and neurological tests, and palpation of your child's joints and muscles using our hands. The chiropractic examination is a “hands-on” approach so that we can best assess your child's health.

Office Policies Please Initial Below

_____I agree to the DC's discussing with other health practitioners at Tillsonburg Chiropractic and Wellness health concerns related to my chief complaint.

_____I agree to DC's releasing proof of attendance and payment information to 3rd party benefit and insurance companies.

_____
Child Name

_____	_____	_____
Parent Name	Parent Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date