Active Living CHIROPRACTIC
FAMILY WELLNESS • ACUPUNCTURE • ORTHOTICS
DR. STEPHEN O'NEIL B.Sc. D.C. C.C.S.P.

☐ Dr. S. O'Neil ☐ Dr. S. Bracken ☐ Dr. G. Fuerth

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Belle River Ontario N0R 1A0
Phone: (519) 728-3366
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CONFIDENTIAL INFANT HEALTH HISTORY

Date: _____ File No.: _____

Patient Information

Name: _____ Sex: ☐ Female ☐ Male

Address: _____

City: _____ Postal Code: _____

Parent or Guardian's Name: _____ H. Phone: _____

Date of Birth: _____/_____/_____ Age: _____ Height: _____ Weight: _____
yr mm dd

MD: _____ Date of last visit: _____ Reason: _____

Ever received chiropractic care? ☐ Yes ☐ No If yes: Reason: _____

Who: _____ When: _____

Referred By: _____

Insurance Information

Do you have Insurance Coverage with Blue Cross, Great West Life, Green Shield, or Standard Life?

If yes, please list companies below. A signed Consent Form is also required.

Ins. Co. 1.: _____

Ins. Co. 2.: _____

Authorization For Care Of A Minor

I hereby authorize Dr. O'Neil, Dr. Bracken or Dr. Fuerth whomever they may designate to administer care as they deem necessary, to my son / daughter.

Signed: _____ Chiropractor: _____

Dated this _____ day of _____, year _____

Patient Name:	File No.:

Chief Complaint

Reason for contacting us? Maximizing health ☐ or

_____

List all therapies undergone for this complaint, including medications. _____

_____

Date of onset: _____ Onset was: ☐ Sudden ☐ Gradual

Duration of problem/episode: _____ ☐ Min ☐ Hours ☐ Days ☐ Months

Pattern of Problem: ☐ Constant ☐ Intermittent ☐ Occasional

How did it start? _____

What aggravates it? _____

What seems to help? _____

Effects of problem on body functions and daily activities: _____

Birth History

Duration of gestation _____ weeks. List any significant complications during pregnancy.

_____

Was delivery normal? ☐ Yes ☐ No

Duration of labour: _____ hours. Presentation of baby: _____

List any complications of delivery: _____

_____

List any medication taken during pregnancy or delivery: _____

_____

Forceps used for delivery? ☐ Yes ☐ No

Place of birth: ☐ Hospital ☐ Home ☐ Birthing Centre

Apgar score at birth _____ Weight at birth _____

Apgar score at 5 min _____ Length at birth _____

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Patient Name:	File No.:

Development History

Was the infant alert and responsive within twelve hours of delivery? ☐ Yes ☐ No

If no, explain: _____

At what age did the child...

Respond to sound	_____	Vocalize	_____
Hold head up	_____	Teethe	_____
Sit alone	_____	Sleep hours	_____
Crawl	_____	Walk alone	_____
Follow an object with his/her eyes	_____	Stand	_____

Any history of significant falls, accidents or trauma? _____

Any hospitalizations, medications? _____

Social Behaviour: Seems normal for age? ☐ Yes ☐ No If no, explain

_____

_____

Nutritional History

Breast fed for_____ months. Formula began age _____ for _____ months.

Type of formula used: _____ Cow's milk began age: _____

Other milk: _____ began age _____ for _____ months.

Began solid foods at age _____ months.

Were commercially prepared baby foods used? ☐ Yes ☐ No Type: _____

Food/juice intolerance? ☐ Yes ☐ No Type: _____

Immunizations: ☐ Yes ☐ No If yes, list type and age _____

Is there a family history of...

	Heart Disease	Stroke	Cancer	Arthritis	Diabetes	High BP	Other
Father's Side	☐	☐	☐	☐	☐	☐	☐_____
Mother's Side	☐	☐	☐	☐	☐	☐	☐_____

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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment FORM - L

CCPA09.08

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Date Signed Print Name of Patient or Legal Guardian

_____ _____

Signature of Patient or Legal Guardian Signature of Chiropractor

Dates Reviewed

Date _____ Signature _____ Witness _____

Date _____ Signature _____ Witness _____

Date _____ Signature _____ Witness _____

Date _____ Signature _____ Witness _____