220 Wexford Road, Unit 2
Brampton, ON L6Z 4N7 (905)840-WELL

- ☐ Dr. Justine Blainey-Broker, B.Sc., D.C.
- ☐ Dr. Blake Broker, B.Sc, D.C.
- ☐ Dr. Steve Gillis, BPE, ART, D.C.
- ☐ Dr. Stephanie Behmer, D.C.
- ☐ Other:

ROF	MON	TUES	WED	THURS
GUEST				

Child (Ages 4-10) Health History Form

Please complete the following as completely as possible. If you need assistance, please ask the front desk staff and they will be glad to assist you.

		DI
CE		
SUB		
X-RAY C/SP		
X-RAY T/SP		
X-RAY L/SP		
X-RAY OTHER		
GAIT		
TOTAL		

Child's Name: ______________________________ Date: ______________

Parent(s) Name: ______________________________

Sibling(s) Name(s) (Ages): ______________________________

Address: ______________________________ City: ______________

Prov.: ______________ Postal Code: ______________

Home Phone: (____) ______________________________ Bus Phone: (____) __________

Date of Birth: ______________ Age: _____ Gender: ☐ M ☐ F

Who may we thank for referring you? ______________________________

Has your child ever received chiropractic care? ☐ Yes ☐ No Chiropractor's Name: ______________

Why This Form Is Important:

In this office, our focus is on helping people to function optimally so that they are stronger, healthier and better able to adapt to the stresses of everyday life. This form gives us a better understanding of the physical, chemical and emotional stresses that can gradually accumulate over time to produce health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

I have read the below statement and consent to the examination and if appropriate, treatment of the above-named minor under my care.

Physicians, Chiropractors, Osteopaths, and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or strokes like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Tests, with or without x-rays, have been performed on you to minimize this risk to yourself. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions. If you have any questions or concerns please speak to your doctor.

I understand all accounts are payable when service is rendered.

Consent to all encompassing Chiropractic treatments knowing the Doctor (s) will discuss ahead of time them with me. (Example: Orthotics, change of technique etc.)

Consent to seeing another JBWC Doctor if/when need. (Example: Time restrictions, scheduling, acute condition needing help and my primary Doctor is away etc.)

I understand that to provide me with health goods and services, the Justine Blainey Wellness Centre will collect some personal information about my child (e.g., home telephone number, address).

I understand that the Justine Blainey Wellness Centre has a Privacy Policy about the collection, use and disclosure of personal information, and steps taken to protect the information and my right to review my personal information.

I agree to the Justine Blainey Wellness Centre collecting, using, and disclosing personal information about me as set above and in the Justine Blainey Wellness Centre's Privacy Policy

I hereby authorize the release of my medical/chiropractic records or copies of the same to such parties that the doctor may deem necessary as it relates to my child's case, and do hereby hold harmless anyone from such actions.

PARENT(S) NAME(S): ______________________________ WORK TEL: ______________

I hereby authorize and consent to the chiropractic evaluation and care of my child.

PARENT/GUARDIAN SIGNATURE: ______________________________ DATE: __________

WITNESS SIGNATURE: ______________________________

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Growth and Development

Any changes from normal growth or development noted? ☐ Yes ☐ No If yes, please explain ______

____

Is the child getting 8 hours of sleep at night? ☐ Yes ☐ No If no, please explain ________________

____

Do you consider the child's eating pattern normal? ☐ Yes ☐ No If no, please explain ________________

____

*If your child has no symptoms or complaints, and are here for wellness services, please check (√) here _____ and skip to "**Family Health Profile**"*

Present Health Complaints/Concerns:

Major: ____

Minor: ____

When did this problem begin? ____

Is this problem: ☐ Occasional ☐ Frequent ☐ Constant ☐ Intermittent

Does problem radiate? ☐ Yes ☐ No If yes, where? ____________________________________

What makes this worse? ____

What makes this better? ____

Is the problem worse during a certain time of the day? ☐ Yes ☐ No If yes, when? ______________________

Does this interfere with the child's ☐ Sleep? ☐ Eating? ☐ Daily Routine?

Is this becoming worse? ____

Other professionals seen for this condition? ____

Results with that treatment? ____

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS: (please check if your child has had any of the following)

☐ Headaches	☐ Loss of Taste	☐ Weight Gain	☐ Upper Back Pain
☐ Dizziness	☐ Light Sensitivity	☐ Dental Problems	☐ Neck Pain
☐ Fainting	☐ Face Flushed	☐ Fevers	☐ Low Back Pain
☐ Fatigue	☐ Cold Sweats	☐ Heart Palpitations	☐ Radiating Pain
☐ Irritability	☐ Bronchitis	☐ Chest Pressure	☐ Stiffness
☐ Depression	☐ Pneumonia	☐ Breast Pain	☐ Reduced Mobility
☐ Loss of Balance	☐ Difficulty Breathing	☐ Frequent Colds	☐ Numbness in Leg(s)
☐ Loss of Concentration	☐ Shortness of Breath	☐ Sinus Congestion	☐ Numbness in Feet
☐ Loss of Memory	☐ Asthma	☐ Sore Throats	☐ Numbness in Hand(s)
☐ Ears Buzzing	☐ Urinary Problems	☐ Ear Pain / Infections	☐ Weakness
☐ Poor Coordination	☐ Constipation	☐ Allergies	☐ Muscle Cramps
☐ Vision Changes	☐ Diarrhea	☐ Heartburn	☐ Sleeping Problems
☐ Loss of Smell	☐ Weight Loss	☐ Bloating / Gas	

☐ Other: ____

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Family Health History

Please note any health issues with family relations:

Brothers: ____

Sisters: ____

Father: ____

Mother: ____

Grandparents: ____

In this office we will perform a thorough assessment of your child's spine to locate areas of **Vertebral Subluxation**. Subluxations are the areas of dysfunction in the spine that interfere with the healthy connection between the nervous system and all the different parts of your body. This will result in compromised health and reduced energy to the tissue which that part of the nervous system supplies. Subluxations are caused by *physical, chemical* and *mental/emotional* stresses that overwhelm the nervous system and spine. Please complete this form to the best of your ability. This will help us to determine the causes of the subluxations we may find.

Physical Stressors

Any significant falls or trauma to the mother during pregnancy? ☐ Yes ☐ No ☐ Unsure

Any evidence of birth trauma as an infant? ☐Yes ☐ No ☐ Unsure

If yes, please explain:____

For the child, were there any falls from couches, beds, during play? ☐ Yes ☐ No ☐ Unsure

Any hospital visits for concussions, possible fractures or other traumas? ☐ Yes ☐ No ☐ Unsure

Have there been any surgeries? ☐Yes ☐ No

If yes, please explain: ____

Is a backpack worn? ☐Yes ☐ No If yes, is it ☐ heavy or ☐light?

Does your child participate in sports? ☐Yes ☐No If yes, how many days/week? ______________

Any hobbies or activities which require prolonged, awkward or repetitive postures? (i.e. violin, gymnastics, etc.)

☐ Yes ☐ No ☐ Unsure

Sport History Injuries: Year: ____________ Injury: ______________________________

Year: ____________ Injury: ______________________________

Vaccination History

Vaccinations and age given? ____

Any negative reactions? ☐Yes ☐ No If yes, what were they? ______________________________

Any antibiotics given? ☐Yes ☐ No Reason?______________________________________

Psychosocial Stressors

Any behavioural problems? ☐Yes ☐ No If yes, what are they? ______________________________

Any ☐ night terrors ☐ sleep walking ☐ difficulty sleeping

Average number of hours of television/iPad per week? _________

Do you feel that your child's social and emotional development is normal for their age? ☐ Yes ☐ No

Any learning difficulties? ☐ Yes ☐ No

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below.