Justine Blainey Wellness Centre

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. Dave Lee, B.Sc., D.C.
☐ Other:_____

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GUEST				

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

Child and Pediatric Health History Form

Please complete to best of abilities

Childs Name:	Date:	
Parent(s) Name:		
Sibling(s) Name(s) (Ages):		
Address:	City:	
Province:	Postal Code:	
Home Phone:	Cell Phone:	
Date of Birth:	Age:	Gender:
Who may we thank for referring you?		
Has your child ever received chiropractic care? Yes☐ No☐	Chiropractors 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

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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):_____

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

PARENT/GUARDIAN SIGNATURE:_____

WITNESS SIGNATURE:_____

WORK TEL:

DATE:

History of Birth

What was the child's gestational age at birth? (Weeks)

Birth Weight (lbs) Oz Birth Length Inches

Was your child's birth: At home ☐ In a birthing center ☐ In a hospital☐

Was the birth considered Medical☐ Midwife☐

What was the duration of the labour and birth? (hours)

Was child born: Cephalic (head first) ☐ Breech (feet first)☐

Were there any complications? Yes ☐ No☐ If yes please explain:_____

Please check any assistance which was used during birth

Forceps☐ Vacuum Extraction ☐ C-Section☐ Episiotomy☐

Was labour Spontaneous☐ Induced☐

Were medications or epidurals given to the mother during birth? Yes☐ No☐

If Yes, explain: _____

APGAR score: at Birth /10 After 5 minutes /10 enter text

Growth and Development

Any changes from normal growth or development? Yes ☐ No☐ If no, Explain _____

Was the infant alert and responsive within 12 hours of delivery? Yes ☐ No☐

If no, please explain:

At what age did the child:	Respond to sound	Follow an object	Hold up head	
Vocalize	Sit alone	Teeth	Crawl	Walk

Do you consider the child's sleep pattern normal? (8 hours) Yes ☐ No ☐

If no, please explain:_____

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*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 part of day? Yes ☐ No ☐	If yes, when?
Does this interfere with the child's Sleeping ☐ Eating ☐ Daily Routine? ☐	
Is this becoming worse?	
Other professionals seen for this condition?	
Results with that treatment?	

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

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

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Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

	Name(s)	Condition(s)
Grandparent(s)		
Sister(s)		
Mother		
Father		
Brother(s)		
Others:		

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 to the infant? Yes ☐ No ☐ Unsure ☐

Bruising ☐ Odd Shaped Head ☐ Stuck In Birth Canal ☐

Fast or Excessively Long Birth ☐ Respiratory Depression ☐ Cord around Neck ☐

For the child, were there any falls from couches, beds, change tables, etc? 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 explain: _____

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

Does your child participate in sports? Yes ☐ No ☐ If yes how many days a week? _____

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

Yes ☐ No ☐ Unsure ☐

Sports History Injuries. Year: _____ Injury: _____

Year: _____ Injury: _____

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Chemical Stressors

Was this child breast-fed? Yes ☐ No ☐ If yes, how long?_____

Formula introduced at what age?_____ What formula?
Introduction of cow's milk at what age?
Began solid foods at what age?_____ Any intolerance? Yes ☐ No ☐ If yes, at what age? Click or tap here to enter text.

During pregnancy, did the mother Smoke Yes☐ No☐ Drink Yes☐ No☐
Any illnesses during the pregnancy? Yes☐ No☐ If yes, what?_____
Any supplements taken during pregnancy? Yes☐ No☐ If yes, what?_____
Any drugs taken during pregnancy? Yes☐ No☐ If yes, what? _____

Any ultrasounds? Yes☐ No☐ How many?_____
Reasons for being done:_____
Any invasive procedures during pregnancy (Eg. Amniocentesis, CVS, etc.)? Yes☐ No☐
If yes, explain_____
Any pets at home? Yes☐ No☐ What kind?_____
Any smokers in the home? Yes☐ No☐

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 difficulties with lactation? Yes ☐ No ☐ If yes, what?_____
Any problems with bonding? Yes ☐ No ☐ If yes, what?_____
Any behavioural problems? Yes ☐ No ☐ If yes, what? _____
Any night terrors ☐ sleep walking ☐ difficulty sleeping ☐

Age of child when he/she began daycare?
Average number of hours of television or electronics 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 ☐ Explain:Click or tap here to enter text.

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.

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www.blaineywellness.com

CONSENT FOR:
☐ Examination
☐ Adjustment
☐ Report of findings

CONSENT TO CHIROPRACTIC TREATMENT AND /OR EXAMINATION

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment. Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise. Discuss forms of treatment with your doctor you are comfortable with.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.
The risks include:

- Temporary worsening of symptoms – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- Skin irritation or burn – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- Sprain or strain – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- Rib fracture – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- Injury or aggravation of a disc – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

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Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.
The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed in most severe cases only.

- Stroke – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke. Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. **Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.** The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

- Consent to all encompassing chiropractic treatments knowing the Doctor(s) will discuss ahead of time them with me. (Example: Orthotics, change of techniques etc.)
- Consent to seeing another JBWC Doctor if/when needed. (Example: Time restrictions, scheduling, acute condition needing help and my primary Doctor is away etc.)
- I understand that the Justine Blainey Wellness Centre has a Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information.
- I understand that I may receive the following: newsletters, Thank you cards, Birthday cards, phone calls, health packages etc. that may be of interest to me.
- 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 case, and do hereby hold harmless anyone from such actions. This only occurs when patient asks in cases of emergency or for safety.

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- ☐ Other:_____

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the examination and/or assessment of my condition and/or the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment and/or examination(s) as proposed to me.

_____	_____	_____
Patient Name (Please Print)	Signature of patient (or legal guardian)	Date

_____	_____	_____
Name of Chiropractor or Assistant	Signature of Chiropractor or Assistant	Date