



# Café of Life Chiropractic

## Pediatric Health History Form

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name(s) of Parent(s): \_\_\_\_\_

Child's Age: \_\_\_\_\_ Date of Birth: D \_\_\_\_\_ /M \_\_\_\_\_ /Y \_\_\_\_\_ Gender:  M  F

Siblings?  No  Yes - Names (ages): \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ ext. \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Name of additional caretaker(s): \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Family doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Has your child ever received chiropractic care?  Yes  No

If yes, who is your child's previous Doctor of Chiropractic? \_\_\_\_\_

The date of last visit: \_\_\_\_\_

The reason for the last visit: \_\_\_\_\_

Other professionals seen for this condition: \_\_\_\_\_

Results with that treatment? \_\_\_\_\_

Recent tests done (list date beside):  Bloodwork \_\_\_\_\_  Urine \_\_\_\_\_  X-Rays \_\_\_\_\_

Other: explain \_\_\_\_\_

Please tick the purpose for your child's visit:

crisis management  early detection of problems  prevention  wellness

maximizing normal growth and development  other: \_\_\_\_\_

### Authorizing Consent for examination of a Minor (under 16 years): Please Read Carefully

In order for the health professional as indicated below to make a determination on the suitability of my child's/guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child's interests.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

Doctor of Chiropractic: Dr. Shaian Mollaret

Address: 32 Berwick Ave. Toronto, ON, M5P 1H1



## Present Health 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?    Yes    No    Eating?    Yes    No    Daily routine?    Yes    No

Is this becoming worse?    Yes    No

Often seemingly unrelated symptoms can manifest as other health concerns..

Please tick if your child has had any of the following

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> headaches             | <input type="checkbox"/> chest pressure       | <input type="checkbox"/> weight loss         |
| <input type="checkbox"/> dizziness             | <input type="checkbox"/> breast pain          | <input type="checkbox"/> weight gain         |
| <input type="checkbox"/> irritability          | <input type="checkbox"/> frequent colds       | <input type="checkbox"/> dental problems     |
| <input type="checkbox"/> fatigue               | <input type="checkbox"/> sinus congestion     | <input type="checkbox"/> fevers              |
| <input type="checkbox"/> depression/anxiety    | <input type="checkbox"/> sore throats         | <input type="checkbox"/> heart palpitations  |
| <input type="checkbox"/> loss of balance       | <input type="checkbox"/> ear pain/infections  | <input type="checkbox"/> numbness in feet    |
| <input type="checkbox"/> loss of concentration | <input type="checkbox"/> asthma               | <input type="checkbox"/> numbness in hand(s) |
| <input type="checkbox"/> fainting              | <input type="checkbox"/> cold sweats          | <input type="checkbox"/> weakness            |
| <input type="checkbox"/> ears buzzing          | <input type="checkbox"/> bronchitis           | <input type="checkbox"/> heartburn           |
| <input type="checkbox"/> poor coordination     | <input type="checkbox"/> pneumonia            | <input type="checkbox"/> muscle cramps       |
| <input type="checkbox"/> vision changes        | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> upper back pain     |
| <input type="checkbox"/> loss of memory        | <input type="checkbox"/> shortness of breath  | <input type="checkbox"/> neck pain           |
| <input type="checkbox"/> loss of smell         | <input type="checkbox"/> allergies            | <input type="checkbox"/> low back pain       |
| <input type="checkbox"/> loss of taste         | <input type="checkbox"/> constipation         | <input type="checkbox"/> radiating pain      |
| <input type="checkbox"/> light sensitivity     | <input type="checkbox"/> diarrhea             | <input type="checkbox"/> sleeping problems   |
| <input type="checkbox"/> face flushed          | <input type="checkbox"/> urinary problems     | <input type="checkbox"/> numbness in leg(s)  |
| <input type="checkbox"/> reduced mobility      | <input type="checkbox"/> bloating/gas         | <input type="checkbox"/> stiffness           |
| <input type="checkbox"/> Other:                |   |  |



## Birth History

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    hospital    other

Was the birth considered:  medical    midwife      Duration of birth: \_\_\_\_\_ hours

Was child born:  cephalic (head first)    breech (feet first)

Were there any complications?  Yes    No      If Yes, please explain \_\_\_\_\_

Assistances used during delivery:  Forceps    Vacuum extraction    C-section    Episiotomy

Was labour:  spontaneous    induced

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

APGAR score: at Birth \_\_\_\_/10      After 5 minutes \_\_\_\_/10

Is there anything else we need to know about the birth  Yes    No

## Growth & Development

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 _____	Teethe _____
	Crawl _____	Walk _____

Does your child sleep:  front    back    side

Do you consider the child's sleeping pattern normal?  Yes    No      How many hours per day? \_\_\_\_\_

If no, please explain \_\_\_\_\_

## Family Health History

Please note any health problems (ie: cancer, hereditary conditions, diabetes, heart disease) that are present in:

Mothers family \_\_\_\_\_

Fathers family \_\_\_\_\_

Siblings \_\_\_\_\_

## Physical Stressors

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.)  Yes    No

If yes, please explain \_\_\_\_\_

Any evidence of birth trauma to the infant?

- bruising                       odd shaped head                       stuck in birth canal                       fast or excessively long birth
- respiratory depression                       cord around neck



Any falls from couches, beds, change tables, etc?  Yes  No

If yes, please explain \_\_\_\_\_

Any traumas resulting in bruises, cuts, stitches or fractures?  Yes  No

If yes, please explain \_\_\_\_\_

Any hospitalizations or surgeries?  Yes  No

If yes, please explain \_\_\_\_\_

Any sports played? \_\_\_\_\_

Is a school backpack used?  Yes  No Is it  heavy or  light?

### Chemical Stressors

Was this child breast-fed?  Yes  No If yes, how long: \_\_\_\_\_

Formula introduced at what age: \_\_\_\_\_ Which formula? \_\_\_\_\_

Introduction of cow's milk at what age: \_\_\_\_\_ Began solid foods at what age: \_\_\_\_\_

Types of solid foods: \_\_\_\_\_

Food/Juice intolerance?  Yes  No Type: \_\_\_\_\_

Is your child on or have taken any medications? \_\_\_\_\_

During the mother's pregnancy:

Did the mother smoke?  Yes  No How much? \_\_\_\_\_

Drink alcohol?  Yes  No How much? \_\_\_\_\_

Any illnesses during the pregnancy?  Yes  No If yes, describe: \_\_\_\_\_

Any supplements taken during pregnancy?  Yes  No If yes, describe: \_\_\_\_\_

Any drugs taken during pregnancy?  Yes  No \_\_\_\_\_

Any ultrasounds?  Yes  No How many: \_\_\_\_\_ Reasons for being done: \_\_\_\_\_

Any invasive procedures during pregnancy (ie amniocentesis, Chorionic villi sampling, etc.)?  Yes  No

If yes, please explain \_\_\_\_\_

Any pets at home?  Yes  No \_\_\_\_\_

Any smokers in the home?  Yes  No

Any antibiotics given?  Yes  No If yes, reason: \_\_\_\_\_

Is the diet organic?  Yes  No Do you use 'green products' in your home for cleaning?  Yes  No

How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet?

Never  On weekends  A few times per week  Daily  Nearly each meal  On special occasions

Are you aware of the impact of nutrition on children's behavior?  Yes  No

Would you like information on nutrition for your child?  Yes  No



**Psychosocial Stressors**

Any difficulties with lactation?  Yes  No \_\_\_\_\_

Any problems with bonding?  Yes  No \_\_\_\_\_

Any behavioral problems?  Yes  No \_\_\_\_\_

Any inattention?  Yes  No \_\_\_\_\_

Any hyperactivity or restlessness?  Yes  No \_\_\_\_\_

Any compulsiveness?  Yes  No \_\_\_\_\_

Any difficulties at daycare or school?  Yes  No \_\_\_\_\_

Any challenges with learning deficiencies?  Yes  No \_\_\_\_\_

Any night terrors, sleep walking, difficulty sleeping?  Yes  No \_\_\_\_\_

Any prolonged temper tantrums or separation anxiety?  Yes  No \_\_\_\_\_

Is the child in day care  Yes  No \_\_\_\_\_

Age of child when began daycare? \_\_\_\_\_

Is there a nanny or regular sitter during the day if both parents work  Yes  No \_\_\_\_\_

Is the child home schooled?  Yes  No \_\_\_\_\_ by Whom? \_\_\_\_\_

Average number of hours of television per week? \_\_\_\_\_ Average number of hours of video games per week? \_\_\_\_\_

Does your child have a cell phone?  Yes  No How often do they text or use the phone? \_\_\_\_\_

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

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Thank you for completing this form. If you have anything to add below, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have, please discuss with the doctor.

**FINANCES**

**Payment in full is expected on all FIRST VISIT services** (whether you have insurance coverage or not.) All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment.  Cash  Check

**First Visit Fees: Comprehensive Exam: \$100 X-Rays (if necessary): \$30**

**Doctor's Report (Second Visit): \$50 Adjustments/Entrainments: \$47**

**INSURANCE INFORMATION**

Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide in our office.. It is your responsibility to contact your insurance company to determine the amount and extent of coverage. **We are unable to submit any insurance forms for you. We will provide account statements upon request that you can use to submit to your insurance provider.**

Is this an Auto Accident Related Injury?  Yes  No

If **yes**, please provide us with the following information:

Has your child been treated elsewhere?  Yes  No

If **yes**, where?  Emergency Room  Primary Care  Other \_\_\_\_\_

What services were provided?  MRI  X-Rays  Medication  Therapy

Other (details) \_\_\_\_\_



**PLEASE READ AND SIGN**

1. I acknowledge that Café of Life Chiropractic has informed me that they are not Blue Cross Blue Shield Providers. Therefore, they cannot guarantee that claims for any services rendered to me by Dr. Shaian Mollaret and/or Cafe of Life Chiropractic under any health plan will be reimbursed.
2. I have been informed that a copy of Café of Life Chiropractic's "Notice of Privacy Practices for Protected Health Information (HIPAA)" brochure is available for my review both in the office and on the website at [www.cafeoflifetoronto.com](http://www.cafeoflifetoronto.com)
3. I consent to receive communication from Café of Life Chiropractic via email, postal mail, text and telephone messaging in connection with my care.  Yes  No If I should withdraw my consent, I will notify the office in writing.
4. I consent to my name (first name, last initial) being posted on the Referral Board when I refer a new patient to Café of Life Chiropractic.  Yes  No If I should withdraw my consent, I will notify the office in writing.
5. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.
6. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policyholder. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company. It is my responsibility to keep my account up to date at Café of Life, and request statements to submit to my insurance company for reimbursement for care provided at Café of Life.

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give Dr. Shaian Mollaret permission to render care to my child today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Child's Name: (Printed)

\_\_\_\_\_

Parent or Legal Guardian's Name:

(Printed) \_\_\_\_\_

Signature \_\_\_\_\_

Date: \_\_\_\_\_

*Thank you for choosing Café of Life Chiropractic.*

*We look forward to helping you*