

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.

Child's Name \_\_\_\_\_ Date \_\_\_\_\_  
Parent(s) Name \_\_\_\_\_  
Siblings Names(Ages) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Prov. \_\_\_\_\_  
Postal Code \_\_\_\_\_ Home Phone(\_\_\_\_) \_\_\_\_\_ Bus Phone(\_\_\_\_) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Referred by \_\_\_\_\_

Has your child ever received chiropractic care? **Yes No**  
If **yes**, previous DC's name and last visit? \_\_\_\_\_  
Name of Medical Doctor \_\_\_\_\_  
Date of last MD visit and reason \_\_\_\_\_

**AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)**  
PARENT(S) NAMES \_\_\_\_\_ WORK TEL. \_\_\_\_\_  
I hereby authorize and consent to the chiropractic evaluation of my child.  
PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
WITNESS SIGNATURE \_\_\_\_\_

**PRESENT HEALTH COMPLAINTS/CONCERNS:**

Major \_\_\_\_\_  
Minor \_\_\_\_\_  
When did this problem begin? \_\_\_\_\_  
Is this problem (circle) **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 tick 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 legs (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:\_\_\_\_\_

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 or in a hospital? (circle one)
Was the birth considered medical or midwife? (circle one)
What was the duration of the labour and birth? \_\_\_\_\_ hours
Was child born cephalic (head first) or breech (feet first)? (circle one)
Were there any complications? Yes No If Yes, please explain\_\_\_\_\_

Please circle any assistance which was used during birth
Forceps Vacuum extraction C-section Episiotomy
Was labour spontaneous or induced? (circle one)
Were medications or epidurals given to the mother during birth? Yes No
If yes, what was given? \_\_\_\_\_
APGAR score: at Birth \_\_\_\_\_/10 After 5 minutes \_\_\_\_\_/10

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 \_\_\_\_\_
Do you consider the child's sleeping pattern normal? Yes No
If no, explain\_\_\_\_\_

**FAMILY HEALTH HISTORY**

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

Mother's family \_\_\_\_\_

Father's family \_\_\_\_\_

Siblings \_\_\_\_\_

**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.**

**PHYSICAL STRESSORS**

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

Please explain \_\_\_\_\_

Any evidence of birth trauma to the infant? (please tick)

\_\_Bruising

\_\_Stuck in birth canal

\_\_Respiratory depression

\_\_Odd shaped head

\_\_Fast or excessively long birth

\_\_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 hospitalization or surgeries? **Yes No**

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

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

Is a school backpack used? **Yes No**

Is it heavy or light (circle one)

**CHEMICAL STRESSORS**

Was the child breast-fed? **Yes No**

Formula introduced at what age? \_\_\_\_\_

Introduction of cow's milk at what age? \_\_\_\_\_

Began solid foods at what age? \_\_\_\_\_

Food/Juice intolerance? **Yes No**

If yes, how long? \_\_\_\_\_

Which formula? \_\_\_\_\_

Type of foods? \_\_\_\_\_

Type? \_\_\_\_\_

During pregnancy, did the mother: Smoke? **Yes No**

Drink? **Yes No**

How much? \_\_\_\_\_

How much? \_\_\_\_\_

Any illnesses during the pregnancy? **Yes No** \_\_\_\_\_

Any supplements taken during pregnancy? **Yes No** \_\_\_\_\_

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

Any ultrasounds? *Yes No* How many and reasons for being done? \_\_\_\_\_  
\_\_\_\_\_

Any invasive procedures during pregnancy (ie amniocentesis, CVS, etc.)? *Yes No*

Please explain \_\_\_\_\_

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

Any smokers in the home? *Yes No*

Vaccination History Vaccinations and age given? \_\_\_\_\_  
\_\_\_\_\_

Any negative reactions? *Yes No* \_\_\_\_\_

Any antibiotics given? *Yes No* Reason \_\_\_\_\_

**PSYCHOSOCIAL STRESSORS**

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

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

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

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

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

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

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

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

**Informed Consent to Chiropractic Treatment**

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 ligamentous 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 have been 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 process. However, you are being informed of this reported association because 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 manual cervical and lumbar spinal adjustment although no scientific study has ever 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 discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (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 spinal adjustment.

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

**Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.**

\_\_\_\_\_  
**Patient Signature** (Legal Guardian)

\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_  
**Patient Name** (please print)

\_\_\_\_\_  
**Witness Name** (please print)

## **OFFICE POLICIES FOR PATIENTS**

*It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.*

### **UPON ARRIVAL**

Please remove your shoes and check in at front desk. Fill out any necessary forms and return them to front desk. One of our health team members will escort or direct you to your adjusting or treatment room.

**Chiropractic** – Once you are in an adjustment room please empty your pockets (keys, wallet etc.) and remove any earrings and long necklaces. **Please lie face down on the table as this will relax your muscles and take the stress of gravity off your spine thus facilitating a more comfortable adjustment.**

**Registered Massage Therapy, Naturopathic Medicine and Alternative Therapies** – Once in your treatment room your practitioner will discuss treatments for the session. This may include areas to be treated, your position on the table, benefits/risks, today's goals and a verbal consent will be obtained before the treatment commences. If you want to change or refuse any part of the treatment at any time you have the right to do so. Your practitioner will then leave the room so that you may undress if necessary and re-enter the room once you are ready. You are covered with sheets at all times; only the area being worked on will be uncovered.

After the treatment your practitioner will suggest a treatment schedule to best suit your individual situation. They may also recommend after care exercises or stretching to further enhance your treatments. You may be asked to complete some paperwork between your treatments to allow your practitioner to fully understand the nature of your issues. Those who follow these recommendations notice better and longer lasting results.

### **YOUR SCHEDULE**

Your specific course of care has been designed just for you by your Health Care Provider and your appointment time has been set aside specifically for you. The importance of keeping your appointments and being on time is crucial to help make our office as efficient as possible for the benefit of all our patients. If you do need to reschedule an appointment we require a minimum of 24 hours notice. Any missed appointments or cancellations without adequate notice may result in a fee being charged to you. Due to the healing nature of your treatments, we request that any missed or cancelled sessions be made up at the earliest available time, ideally within 24 hours. Please understand that as a patient you are responsible for any and all charges incurred during the course of your treatment at our wellness centre. When seeing multiple health team members we will do our best to align your appointments together because we value your time as well. If requested, a personal appointment calendar can be supplied to you.

### **REFERRALS**

Once you understand the importance and benefits provided by each of our Health Care Providers, we are confident that you will want everyone in your family checked. The nicest compliment you can give our clinic is to refer us to your family and friends. Please feel free to ask anyone on our health team for any literature you may require.

Welcome to our Health and Wellness Family.

**I agree and understand the above policies. Signed** \_\_\_\_\_