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 gai*n	__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*** How much?_____
Drink? ***Yes*** ***No*** 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 _____

16775 Yonge Street, Suite 214, Newmarket, On. L3Y 8J4
☎ 905 898 6644 www.mychiro.org

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_____ _____

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