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Chiropractic - Pediatric New Patient Information

Please note that all the information you provide will be kept confidential.

Date: _____

Patient Information

Child's Name: _____ Sex: _____
Date of Birth: _____ Age: _____
Care Card #: _____

Address: _____ City _____
Postal Code: _____

Family Information

Mother's Name: _____ Father's Name: _____
Home Phone: _____ Home Phone: _____
Work Phone: _____ Work Phone: _____

Ages of Other Children in Family: _____

Other HealthCare Providers

Name: _____ Name: _____
Address: _____ Address: _____
Phone: _____ Phone: _____

Reason for Visit

Please list your current health concerns for your child

Is your child currently taking any medications or supplements? If so, please list them:

Newborn History

Please complete this section with respect to your child's first 18 months.

Were there any difficulties with pregnancy, labour or delivery? _____
Does (did) your baby go to sleep easily? _____
Does (did) your baby have a preferred sleeping position? _____
Is (was) your baby being breast fed? _____
For how long was your baby breast fed? _____ Weeks/months
Does (did) your baby cry a lot? _____
If yes, for many hours each day? _____
Does (did) your baby cry or become irritable during a diaper change? _____
Has (did) your baby had a fever? _____
Has (did) your baby had any falls? _____
Has (did) your baby been in a car accident? _____
Has (did) your baby had any other trauma? _____

Early Childhood History

Please also complete this section if your child has reached 18 months of age.

Does your child have any serious or chronic illnesses? _____
Has your child had any accidents or trauma? _____
Has your child been hospitalized for any reason? _____
Has your child had surgery? _____

Have you noticed any significant changes in your child's personality and/or behaviour? _____

Please let us know of any concerns that you would like to discuss:

Office Payment Policies

As posted, our fees are as follows:

Initial Visit (Examination and 1 st treatment)	\$70
Second visit/Report of Findings	\$55
Subsequent Visit:	\$40
Extended Visit: Intended for Acute Situations requiring additional care or a closer examination of two or more areas	\$75

Your appointment time is reserved for you. Please note that to cancel or reschedule your appointment, a minimum of 24 hours notice is required to avoid a late cancellation fee of \$25.



CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
Informed Consent to Chiropractic Treatment FORM – L

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 ligament 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 are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship 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 already a stroke in progress. However, you are being informed of this reported association because a 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 identified following cervical and lumbar spinal adjustment although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other 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 read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatments recommended to me by my chiropractor, including any recommended 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 of Signature

Name: _____
(please print)

Name: _____
(please print)