mountain CHIROPRACTIC & natural health

Pediatric New Patient Chiropractic Form

The information requested below will assist us in treating you safely. Please feel free to ask any questions about the information that we require. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

If your information changes in the future, please let us know. **Date:**_____

Name: **Parents Names:**	**Parents/Guardians Phone Numbers:**
Address: Street: _____ Town: _____ Postal Code: _____ _____ Province: _____ Emergency Contact Name & Number:_____	Did a health care practitioner refer your child? Yes □ No □ If Yes, Name: _____ Location: _____ If No, who referred you? Do you have extended Health Coverage? Yes □ No □ Name of previous Chiropractor:
Parent or Guardian's Email:	**Name of family physician:**
Sex: M / F	**Date of Birth:** _____/_____/_____ Age: _____ M D Y

Has your child ever suffered from any of the following?

□ Diabetes
□ Arthritis
□ Neuritis
□ Rheumatic Fever
□ Convulsions
□ Bed Wetting
□ Fainting
□ Neck Problems
□ Joint Problems
□ Backaches
□ Tuberculosis
□ Headaches
□Sinus Trouble
□ Anemia
□ Poor Appetite
□ Paralysis
□ Broken Bones
□ Arm Problems
□ Blood Disorders
□ Heart Trouble
□ Hypertension
□ Asthma
□ Constipation
□ Diarrhea
□ Hyperactivity
□ Muscle Jerking
□ Ruptures/Hernia
□ Leg Problems
□ Stomach Aches
□ Chronic Earaches
□ Colds/Flu
□ Allergies
□ Digestive Disorders
□ Orthopedic Problems
□ Behavioural Problems
□ Sugar Concentration
□ Walking Problems
□ Growing Pains
□ Other?

_____

Please note any health issues that are present with family relations:

Mother

_____

Father

_____

□ Sister/ □ Brother

_____

Grandparents

Birth History

Child's gestational age at birth _____

Birth Weight:_____
Birth Length: _____

Birth Experience:
□ Midwife
□ Medical

Labour:
□ Spontaneous
□ Induced

Any procedures during birth?
□ Forceps
□ Vacuum Extraction
□ C-section
□ Episiotomy

If Yes, Explain:

_____
_____

Evidence of obvious birth trauma:
□ Bruising
□ Odd shaped head
□ Stuck in birth canal
□ Cord around neck

Any significant falls/trauma to the mother during pregnancy?
□ Yes □ No □ Unsure

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?
If Yes, Explain:

_____
_____

Current Health Concern & Physical Stresses:

Health Concern:

Has he/she experienced this before? Yes □ No □

How long have they had this for?

How often do they experience this? □ Daily □ Couple of times a week □ Randomly

What makes it feel worse?

What makes it feel better?

Have they been seen by other professionals for this concern? (Please include treatment and results)

Does your child wear a backpack? Yes □ No □ If yes, is it Heavy □ Light □

Does your child participate in sports? Yes □ No □

Does your child participate in hobbies/activities which require prolonged, awkward or repetitive postures? Yes □ No □

Please tell us about the hobbies or activities (ex: violin, gymnastics, computer/video games, etc):

Chemical Stresses:

During the pregnancy did the mother: 1. Use medications? Yes □ No □ If yes, which ones? _____

2. Smoke? Yes □ No □

3. Drink? Yes □ No □

Was the child breast-fed? Yes □ No □ If yes, how long? _____

Formula introduced at what age? _____ Began solid foods at what age? _____

Vaccinations given:

Any reactions? Yes □ No □ If yes, please list: _____

Mental/Emotional Stress:

Any problems with bonding? Yes □ No □ Any behavioural problems? Yes □ No □

Any night terrors, sleep walking, or difficulty sleeping? Yes □ No □

Average number of television hours per week? _____

Do you feel that your child's social and emotional development in appropriate for their age? Yes □ No □

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Consent to Chiropractic Treatment

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and 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.

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 headaches, 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 only last 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 ill 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.

  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.

- **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 exists 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 you chiropractor immediately of any change in your condition.

Please initial the following boxes if you consent to the following:

☐ I agree to give Mountain Chiropractic and Natural Health **24 hours notice** should I need to cancel an appointment. I understand that if I fail to do so, I will be subject to **paying the full amount of the appointment**.

☐ I give my consent to receive periodic e-mails and newsletters from Mountain Chiropractic and Natural Health, which may include appointment reminders, schedule changes, promotions and other helpful information that we wish to share with our clients.

☐ I consent to professional collaboration of my case (RMT, Physician, Naturopath, Acupuncturist, etc.) where it would benefit my care.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and 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 as proposed to me.

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