Chiropractic Paediatric New Patient Form

The information requested below will assist us in treating you safely. All personal health information will be kept confidential unless it is released with your written consent or is required to be released by law. If your information changes in the future, please keep us updated.

Child's Name:			**Today's Date:**
Date of Birth (dd/mm/yyyy):	**Age:**	**Sex:**	**Emergency Contact Name & Number:**
Parent/Legal Guardian Name(s):			**Family Physician:**
Cell Number:	**Home Number:**		**Previous Chiropractor:**
Email:			Do you have extended health coverage? Yes □ No □ Insurance Company: _____
Address: Number & Street: _____ Town & Province: _____ Postal Code: _____			Did a health care practitioner refer you? Yes □ No □ If Yes: Name: _____ Location: _____ If No: Who referred you? _____

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
□ Walking Problems
□ Growing Pains
□ Other?

Please note any family health issues:

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

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

Any significant falls/trauma for the child 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:
_____
_____
_____
_____

Name:

Describe what your child is feeling.

_____

_____

Have they experienced this before? Yes □ No □

How long ago did their symptoms start? _____

How frequently do they experience symptoms? Daily □ Weekly □ Monthly □ Randomly □

Please rate their level of discomfort: 1 2 3 4 5 6 7 8 9 10

What were they doing when this began?

_____

What makes it feel better?

_____

What makes it feel worse?

_____

Have they been seen by other health professionals for this concern? What was the treatment and result?

_____

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

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

Please list the sports/hobbies/activities in which your child participates (ex: violin, gymnastics, video games, etc.):

_____

Chemical Stresses:

During the pregnancy did the mother: Use medications? Yes □ No □ If yes, which ones? _____
Smoke cigarettes? Yes □ No □
Drink alcohol? Yes □ No □

Was the child breast-fed? Yes □ No □ Formula introduced at what age? _____

If yes, how long? _____ Began solid foods at what age? _____

Vaccinations given: _____

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

Name:

Mental/Emotional Stresses:

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

Does your child watch television? Yes □ No □ Average number of hours per week? _____

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

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

Is there anything else that I should know and have not asked?

_____

_____

The chiropractor will review your child's health history with you to ensure all information is accurate and complete. Following this, they will conduct a physical examination of your child's joints, muscles and nerves. This will assist in forming a working diagnosis and determining the best plan of management for their complaint. After speaking with the chiropractor, please sign below to give consent for examination for your child.

I give consent for physical examination: _____
Parent/Guardian Signature

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

☐ I agree to give Mountain Chiropractic & 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 fee**.

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

☐ I give consent to professional collaboration of my child's case (Physician, RMT, Naturopath, Acupuncturist, etc.) as well as online viewing of their x-rays where it would be applicable and beneficial to their care.

☐ I have the legal authority to make health care decisions on behalf of the child for which I am signing this form.

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about 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. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____
Patient Name (print)

_____ _____ _____
Patient/Guardian Signature Date Chiropractor Signature