Pickering Chiropractic

Health Centre

Chiropractic Intake Form Child

Pickering Chiropractic Health Centre
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Patient Information

Patient Name: . . . . . Parent(s) Name: . . . . . Date: . . . . . .

Address: . . . . . City: . . . . . Province: . . . . . Postal Code: . . . . . .

Parent Cell #: . . . . . Home #: . . . . . Parent E-mail: . . . . . .

Birth Date: (dd/mm/yyyy). . . . . Age: . . . . . Gender: ☐ Male ☐Female

Medical Information

Family Physician Name: . . . . . Referred By: . . . . . .

Has your child ever received Chiropractic Care? ☐ Yes ☐ No

* Communication between healthcare providers can greatly improve the quality and safety of patient care. If necessary, do you consent to allow your health provider to contact your medical doctor? ☐ Yes ☐ No

Extended Health Benefits & Other Insurance

Card Holder name . . . . . Policy #. . . . . Member ID#. . . . . .

Card Member DOB. . . . . Signature for authorization. . . . . .

Is this a Motor Vehicle Accident Case (MVA)? ☐ Yes ☐ No Date of Accident? . . . . . .

Mother's Pregnancy

Carried to full term: ☐ Yes ☐ No; Epidural used: ☐ Yes ☐ No; Was it a difficult birth? ☐ Yes ☐ No

Describe any complications and when they occurred. . . . . .

. . . . . .

Baby's APGAR Score: . . . . . Score at 5 minutes: . . . . . .

Check all that apply: ☐ Midwife ☐ Hospital ☐ Obstetrician ☐ Induced ☐ C-Section ☐ Forceps used ☐ Vacuum extraction

Breastfeed? ☐ Yes ☐ No How long? . . . . . What formula after? . . . . . .

Did mom smoke during pregnancy? ☐ Yes ☐ No; Consume alcohol? ☐ Yes ☐ No

Any exposures to ultrasound? ☐ Yes ☐ No; How many? . . . . . .

Any medication taken during pregnancy? ☐ Yes ☐ No; For what & what type? . . . . . .

As a baby/toddler (birth to 4 years), did any of the following occur?

☐ Any falls from a height
☐ Involved in a car accident: When? . . . . . .
☐ Frequent bouts of diarrhea
☐ Constipation
☐ Sleeping troubles
☐ Frequent ear infections
☐ Tonsillitis
☐ Fall off play equipment
☐ Play in "Jolly Jumpers"
☐ Frequent fevers
☐ Frequent colds
☐ Colic
☐ Reaction to vaccination
☐ Frequent crying spells

☐ Other: Explain . . . . . .

As a young child (5 to 12 years), did any of the following occur?

☐ Bed wetting
☐ Learning difficulties
☐ Involved in a car accident: When? . . . . . .
☐ Asthma
☐ Stomach pains
☐ Hyperactivity/Autism
☐ Sports accident or falls
☐ Pain in legs ☐ Knee
☐ Allergies
☐ Scoliosis

☐ Other: Explain . . . . . .

As a child or adolescent (13 to 18 years), have they experienced any of the following?

☐ Headaches ☐ Dizziness ☐ Fatigue
☐ Ringing in ears ☐ Allergies ☐ Sleeping problems
☐ Asthma ☐ Sport injuries ☐ Hyperactivity
☐ Stomach problems ☐ Growing pains ☐ Weight gain/loss
☐ Tingling in arm ☐ legs ☐ Pain in back ☐ neck ☐ shoulder
☐ Numbness or pain in arm/hands ☐ foot/ankle ☐ knees

☐ Other: Explain . . . . . .

Which problem is the worst, of those you have checked? . . . . . .
Is this problem: ☐ Constant ☐ Intermittent ☐ Occasional ☐ Cyclic
How long has this persisted? . . . . . When at its worse, how does it make your child feel? . . . . . .

What have you done, that has NOT worked? . . . . . What makes it worse? . . . . . .
What effect does this have on your child's bodily functions? . . . . . On daily activities? . . . . . .
Describe any hospital stays: . . . . . Your child's current medications? . . . . . .
Approximately how many times have antibiotics been prescribed and for which condition(s)? . . . . . .
To summarize, what is your purpose for this appointment? . . . . . .

Do NOT sign this form until you meet with the Chiropractor

Patient Informed Consent to Chiropractic Treatment

Doctors of Chiropractic are required to advise patients that there are or may be some remote risks associated with such treatment. You should note: while rare, some patients may experience a short-term aggravation of symptoms, rib fracture, muscle and ligament strains or sprains, strokes and disc injuries. 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 (including spinal adjustment) as well as the contents of this consent. I consent to the chiropractic treatment offered or recommended to me by my chiropractor, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care. I understand that it is fully my responsibility to pay Pickering Chiropractic for my care at the time of treatment and to confirm with my insurance provider (if applicable) as to coverage for chiropractic care, x-rays, acupuncture and orthotics. Appropriate receipts will be provided for me to submit; however, Pickering Chiropractic is not responsible if I am denied coverage.

Date: _____, 20___

_____ _____
Patient's Guardian Signature Witness Signature

_____ _____
Patient's Guardian Name (Please Print) Witness Name (Please Print)