

# CONFIDENTIAL PEDIATRIC PATIENT INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
City, Province  
Postal Code

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Telephone Home: (\_\_\_\_) \_\_\_\_\_  
Mother Business: (\_\_\_\_) \_\_\_\_\_ e-mail: \_\_\_\_\_  
Father Business: (\_\_\_\_) \_\_\_\_\_ e-mail: \_\_\_\_\_

What is the best time to reach you? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Home: \_\_\_\_\_ Business: \_\_\_\_\_

How were you referred to Waterloo North Chiropractic? \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ (DD/MM/YY)

Height: \_\_\_\_\_ (ft) \_\_\_\_\_ (in) Weight: \_\_\_\_\_ (lbs)  
Birth Height: \_\_\_\_\_ (ft) \_\_\_\_\_ (in) Birth Weight: \_\_\_\_\_ (lbs)

Handedness:

- Right  Both  
 Left  Don't know yet

Sleep: \_\_\_\_\_ Hours per night

- On back  
 On side  
 On stomach

Type of bed: \_\_\_\_\_

***\*\*If this is an injury that is to be covered by automobile insurance, please inform the receptionist.***

## **Consent to Consultation and Examination**

*I consent to consultation and examination to determine if chiropractic treatment would be beneficial to me. I understand that the examination may cause some tenderness and/or discomfort, but that it will be short-lived.*

Name (print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Dr. Jennifer Heick**  & **Dr. Rebecca Blackburn**   
550 Parkside Drive, Unit A4, Waterloo ON N2L 5V4  
519-746-3838 | wncm@rogers.com | www.wncm.ca

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (DD/MM/YY)

## **Birth History**

Type of Birth:

- |   |  |
|---|--|
| <input type="checkbox"/> Normal Vaginal | <input type="checkbox"/> Home            |
| <input type="checkbox"/> Forceps        | <input type="checkbox"/> Birthing Center |
| <input type="checkbox"/> Vacuum         | <input type="checkbox"/> Hospital        |
| <input type="checkbox"/> Breech         |  |
| <input type="checkbox"/> Cesarean       |  |

Describe pregnancy (ie. problems, medications, etc.):

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Were there any drugs used for delivery? If so, please list: \_\_\_\_\_

APGAR Scores: \_\_\_\_\_

Duration of gestation: \_\_\_\_\_ weeks

Was there presence at birth of:

- Jaundice (yellow)                       Cyanosis (blue)

Describe any congenital anomalies/ defects: \_\_\_\_\_

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## **Developmental History**

At what age did the child:

- |                          |                    |
|--------------------------|--------------------|
| • Respond to sound _____ | • Crawl _____      |
| • Notice an object _____ | • Stand _____      |
| • Hold up head _____     | • Walk alone _____ |
| • Sit alone _____        |                    |

Has the child had any of the following childhood diseases:

- |   |  |
|---|--|
| <input type="checkbox"/> Chickenpox               | <input type="checkbox"/> Rubeola (Measles) |
| <input type="checkbox"/> Mumps                    | <input type="checkbox"/> Whooping Cough    |
| <input type="checkbox"/> Measles                  | <input type="checkbox"/> Other: _____      |
| <input type="checkbox"/> Rubella (German Measles) |  |

Was the child breast-fed? \_\_\_\_\_ If yes, for how long? \_\_\_\_\_



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**Current Condition**

*If the child has a specific condition, please complete the questions below or otherwise proceed to the next section of this form.*

What is the major complaint? \_\_\_\_\_

How long has s/he had this condition? \_\_\_\_\_

Did it begin:

- suddenly
- gradually

Is the condition:

- getting better
- getting worse

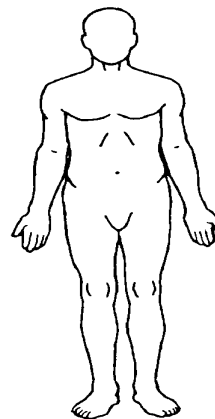
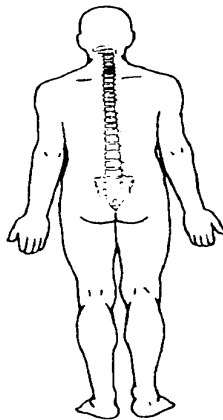
Is there pain:

- consistent
- comes and goes
- at night
- on coughing &/or sneezing

Describe if the pain travels: \_\_\_\_\_

Please mark your area(s) of concern using the symbols that you feel best describe what you are experiencing:

- Numbness**    - - - - -
- Burning**    # # # # #
- Stabbing**    + + + + +
- Pins & Needles**    : : : : :
- Aching**    \* \* \* \* \*
- Stiff / Tight**    / / / / /



Place an "X" on the line to indicate the amount of pain/discomfort associated with your condition:  
No Pain [0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10] Worst Pain Ever

What activities or positions cause aggravation: \_\_\_\_\_

What activities or positions provide relief: \_\_\_\_\_

Please describe any past episodes: \_\_\_\_\_

If there was an injury or event that lead up to this condition, please describe: \_\_\_\_\_

If any health practitioner has previously treated him or her for this condition, please specify:

Location: \_\_\_\_\_ When: \_\_\_\_\_

Nature of Treatment: \_\_\_\_\_

Other areas of concern: \_\_\_\_\_



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### Health History

Please indicate any current or past conditions:

#### GENERAL

allergies /food sensitivities \_\_\_\_\_  
 depression \_\_\_\_\_  
 dizziness \_\_\_\_\_  
 fainting \_\_\_\_\_  
 fatigue \_\_\_\_\_  
 fever \_\_\_\_\_  
 headaches \_\_\_\_\_  
 loss of sleep \_\_\_\_\_  
 loss of weight \_\_\_\_\_  
 nervousness \_\_\_\_\_  
 sweats \_\_\_\_\_  
 tremors \_\_\_\_\_

#### MUSCLE AND JOINT

arthritis \_\_\_\_\_  
 bursitis \_\_\_\_\_  
 clumsiness \_\_\_\_\_  
 hernia \_\_\_\_\_  
 low back pain \_\_\_\_\_  
 neck pain/stiffness \_\_\_\_\_  
 shoulder pain \_\_\_\_\_  
 pain in arms or hands \_\_\_\_\_  
 pain in legs or feet \_\_\_\_\_  
 sciatica \_\_\_\_\_  
 spinal curvature \_\_\_\_\_  
 swollen joints \_\_\_\_\_  
 weakness \_\_\_\_\_

#### GASTROINTESTINAL

colitis \_\_\_\_\_  
 constipation \_\_\_\_\_  
 diarrhea \_\_\_\_\_  
 difficult digestion \_\_\_\_\_  
 gall bladder problems \_\_\_\_\_  
 heart burn \_\_\_\_\_  
 hemorrhoids \_\_\_\_\_  
 jaundice/liver problems \_\_\_\_\_  
 nausea/vomiting \_\_\_\_\_  
 pain over stomach \_\_\_\_\_

#### EYE/EAR/NOSE/THROAT

asthma \_\_\_\_\_  
 colds \_\_\_\_\_  
 deafness \_\_\_\_\_  
 double vision \_\_\_\_\_  
 earaches/ear discharge \_\_\_\_\_  
 ear ringing/buzzing \_\_\_\_\_  
 enlarged glands \_\_\_\_\_  
 blurred vision \_\_\_\_\_  
 enlarged thyroid \_\_\_\_\_  
 eye pain \_\_\_\_\_  
 near or far sightedness \_\_\_\_\_  
 hoarseness \_\_\_\_\_  
 nose bleeds \_\_\_\_\_  
 sinus infection \_\_\_\_\_  
 slurred speech \_\_\_\_\_  
 hay fever \_\_\_\_\_  
 sore throat \_\_\_\_\_

#### CARDIOVASCULAR

hardening of arteries \_\_\_\_\_  
 high blood pressure \_\_\_\_\_  
 low blood pressure \_\_\_\_\_  
 pain over heart \_\_\_\_\_  
 poor circulation \_\_\_\_\_  
 rapid heart beat \_\_\_\_\_  
 slow heart beat \_\_\_\_\_  
 swelling of ankles \_\_\_\_\_  
 cold hands/feet \_\_\_\_\_

#### RESPIRATORY

chest pain \_\_\_\_\_  
 chronic cough \_\_\_\_\_  
 difficulty breathing \_\_\_\_\_  
 wheezing \_\_\_\_\_

#### SKIN

bruise easily \_\_\_\_\_  
 varicose veins \_\_\_\_\_

#### GENITO URINARY

bed wetting \_\_\_\_\_  
 frequent urination \_\_\_\_\_  
 inability to control \_\_\_\_\_  
 painful urination \_\_\_\_\_  
 prostate trouble \_\_\_\_\_

Obstetrician / Midwife: \_\_\_\_\_

Pediatrician / Family MD: \_\_\_\_\_

Date of last visit to MD: \_\_\_\_\_ Purpose: \_\_\_\_\_

Describe any previous chiropractic care (if applicable):

Location: \_\_\_\_\_ When: \_\_\_\_\_

Has the child ever had any x-rays taken?

No  Yes...What areas of the body? \_\_\_\_\_

Has the child ever:

- used a crutch / cane/ support
- had a fractured bone
- had any sprains or strains



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If the child has ever been hospitalized, please specify.

Location: \_\_\_\_\_ When: \_\_\_\_\_

Nature of Treatment: \_\_\_\_\_

What medication has the child taken in the last 3 months:

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> Muscle Relaxant     | <input type="checkbox"/> Sedative    | <input type="checkbox"/> Antacids          |
| <input type="checkbox"/> Pain Killers        | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Vitamins          |
| <input type="checkbox"/> Anti-Inflammatories | <input type="checkbox"/> Insulin     | <input type="checkbox"/> Natural Therapies |

Other: \_\_\_\_\_

Please describe the child's nutrition and eating habits:

\_\_\_\_\_  
\_\_\_\_\_

Please describe the child's activity level:

\_\_\_\_\_  
\_\_\_\_\_

### **Family History**

Has anyone in your family had any of the following conditions:

- |   | Relationship |   | Relationship |
|---|--------------|---|--------------|
| <input type="checkbox"/> Ankylosing spondylitis | _____        | <input type="checkbox"/> Diabetes (type?)   | _____        |
| <input type="checkbox"/> Autoimmune disorder    | _____        | <input type="checkbox"/> Back Pain          | _____        |
| <input type="checkbox"/> Arthritis/Rheumatism   | _____        | <input type="checkbox"/> Multiple Sclerosis | _____        |
| <input type="checkbox"/> Headaches              | _____        | <input type="checkbox"/> Muscular Dystrophy | _____        |
| <input type="checkbox"/> High Blood Pressure    | _____        | <input type="checkbox"/> Stroke             | _____        |
| <input type="checkbox"/> Low Blood Pressure     | _____        | <input type="checkbox"/> Scoliosis          | _____        |
| <input type="checkbox"/> Cardiac Problems       | _____        | <input type="checkbox"/> Cancer (type?)     | _____        |

Chiropractic is beneficial for restoring, maintaining and improving health and wellness. Please indicate the goals you wish your child to achieve by visiting this clinic:

- Dealing with current health problem
- Maintaining health
- Improvement of health



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**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 between chiropractic treatment and the occurrence of stroke. Recent studies suggest 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 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 treatment recommended to me by my chiropractor including any recommended spinal adjustments.

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)

