

CONFIDENTIAL PEDIATRIC PATIENT INFORMATION

Child's Name: _____ Date: _____

Mother's Name: _____ Father's Name: _____

Address: _____
 _____ City, Province

_____ Postal Code

Telephone Home: (____) _____

Mother Alternate Phone: (____) _____ e-mail: _____

Father Alternate Phone: (____) _____ e-mail: _____

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

Emergency Contact: _____ Phone: _____

How were you referred to Waterloo North Chiropractic? _____

Family Doctor: _____ Phone: _____

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

Office Use Only:

Consent			Info	
Chiro		GT		
		Laser		
		Acu		



Name: _____

Date of Birth: _____(DD/MM/YY)

Patient Information:

Current Height: _____(ft)_____(in) Current Weight: _____(lbs)

Birth Height: _____(ft)_____(in) Birth Weight: _____(lbs)

Handedness:

- Right
- Left
- Both
- Don't know yet

Sleep: _____ Hours per night

- On back
- On Side
- On Stomach

Type of bed: _____

Birth History

Birth Type:

- Normal Vaginal
- Forceps
- Vacuum
- Breech
- Cesarean
- Home
- Birthing Center
- Hospital

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

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: _____

Developmental History

At what age did the child:

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

Has the child had any of the following childhood diseases?:

- Chickenpox
- Mumps
- Measles
- Rubella (German Measles)
- Whooping Cough
- Other: _____

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



Name: _____

Date of Birth: _____(DD/MM/YY)

Current Condition

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

What is the major complaint? _____

How long has he or she had this condition? _____

Did it begin:

suddenly

gradually

Is the condition:

getting better

getting worse

consistent

comes and goes

Is there pain:

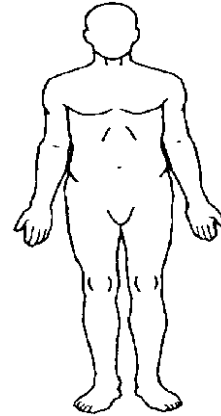
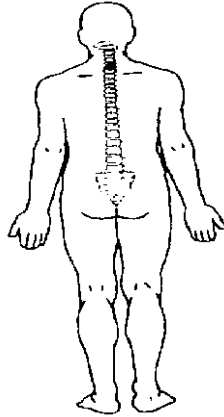
at night

on coughing &/or sneezing

Describe if the pain travels: _____

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

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



Place an "X" on the line to indicate the amount of pain/discomfort associated with the child's 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: _____



Name: _____

Date of Birth: _____(DD/MM/YY)

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: _____

If the child has ever been hospitalized, please specify:

Location: _____ When: _____

Nature of Treatment: _____

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



Name: _____

Date of Birth: _____(DD/MM/YY)

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

Consent to Consultation and Examination

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

As of today’s date, I have the legal right to select and authorize health care services for the minor child named below. The consent of a spouse, former spouse, or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will notify this office immediately.

Child’s Name (please print)

Parent/Guardian’s Name (please print)

Parent/Guardian’s Signature

Date



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

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 to 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 headache, 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 last only 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 will 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 existed 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 your chiropractor immediately of any change in your condition.

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: _____ 20____

Signature of chiropractor Date: _____ 20____

