File #_____

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		

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

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? _____

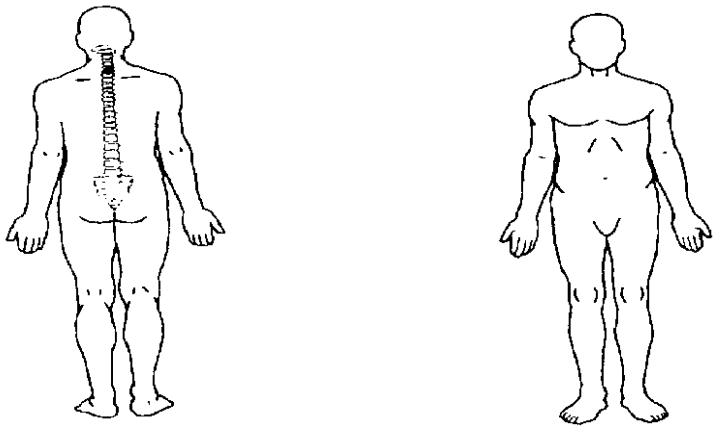
How long has he or she had this condition? _____

Did it begin:	Is the condition:		Is there pain:
☐suddenly	☐getting better	☐consistent	☐at night
☐gradually	☐getting worse	☐comes and goes	☐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?

- ☐ Muscle Relaxant
- ☐ Pain Killers
- ☐ Anti-Inflammatories
- ☐ Sedative
- ☐ Antibiotics
- ☐ Insulin
- ☐ Antacids
- ☐ Vitamins
- ☐ 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
☐ Ankylosing spondylitis	_____	☐ Diabetes (type?)	_____
☐ Autoimmune disorder	_____	☐ Back Pain	_____
☐ Arthritis/Rheumatism	_____	☐ Multiple Sclerosis	_____
☐ Headaches	_____	☐ Muscular Dystrophy	_____
☐ High Blood Pressure	_____	☐ Stroke	_____
☐ Low Blood Pressure	_____	☐ Scoliosis	_____
☐ Cardiac Problems	_____	☐ 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

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)

_____ Date: _____ 20____
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of chiropractor