NEW PATIENT PEDIATRIC INTAKE FORM

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know If there is any way we can make you and your family feel more comfortable. Many types of stressors (physical, mental and chemical) can interfere with your child's growing brain, spine and nervous system. To help us serve you better, please complete the following history information about your child. We look forward to working with you to build a better future for your family.

Childs Name_____ Today's Date_____/____/_____

☐Male ☐Female Weight _____lbs Height____ft. _____in. Birth Date _____/____/_____

Address_____ City_____ Province_____ Postal Code_____

Parents/Guardians Names_____ Phone #_____

Parent/Guardian's email:_____ Referred by_____

MH PHIN (9 digit): _____ MH REG (6 digit): _____

Reason for pursuing care: ☐ Maintenance ☐ Improved Health ☐ Problem: _____

Check any of the following conditions that currently apply:

☐ Ear infections ☐ Scoliosis ☐ Chronic colds ☐ Headaches ☐ Allergies

☐ Digestive problems ☐ ADD/ADHD ☐ Recurring fevers ☐ Colic ☐ Asthma

☐ Growing/back pains ☐ Bed wetting ☐ Seizures ☐ Temper tantrums ☐ Car accident

Other conditions: _____

Other doctors seen for this condition (please include doctor's name and prior treatment):

_____

_____

Previous Chiropractic Care: ☐ yes ☐ no Last visit_____

Name of Pediatrician: _____ Last visit:_____

# of doses of antibiotics your child has taken in the past 6 months_____ total lifetime_____

Present prescription drugs/dosage_____

Past prescription drugs/dosage_____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.) _____

Prenatal History (check what applies)

Name of Obstetrician/Midwife:_____

Complications during pregnancy/ delivery? ☐ yes ☐ no Explain:_____

Ultrasounds during pregnancy? ☐ yes ☐ no How many?_____

Medications taken during pregnancy/ delivery? ☐ yes ☐ no List:_____

Cigarette/ Alcohol use during pregnancy? ☐ yes ☐ no

Location of birth: ☐ Hospital ☐ Birthing Center ☐ Home

Birth Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ Caesarian Section

If Caesarian Section, was it: ☐ Emergency ☐ Planned

Genetic disorders/ disabilities? ☐ yes ☐ no List:_____

Birth Weight:_____ Birth Length:_____ APGAR Scores:_____

Feeding History

Breast Fed: ☐ yes ☐ no How long?_____ Formula fed: ☐ yes ☐ no How long?_____ Type_____

Introduced to: Solid foods @_____months Cow's milk @_____months

Food/ Juice allergies or intolerances: ☐ yes ☐ no List:_____

Developmental History (to the best of your knowledge)

Your child's spine is vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). Spinal nerve interference can affect the following. At what age was your child able to:

_____ Respond to stimuli _____ Cross Crawl _____ Stand alone

_____ Respond to visual stimuli _____ Hold head up _____ Walk alone

_____ Sit up

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs) Did your child have a fall similar to what was described above?

☐ yes ☐ no Explain:_____

Other traumas not described above (bike wipe out, trampoline injury, etc.)?

_____

_____

Has your child been involved in any sports? ☐ yes ☐ no List:_____

_____

Has your child been seen by a physician on an emergency basis? ☐ yes ☐ no

Explain:_____

_____

Lifestyle (please check all that apply):

Does your child: ☐ eat healthy food (organic products, etc.) ☐ drink water

☐ take probiotics ☐ take vitamins Type:_____

Exercise: ☐ none ☐ mild ☐ moderate ☐ heavy ☐ daily

Hobbies/ interests: _____

_____

Is there anything else you would like us to know about your child? _____

_____

_____

Parent/ Guardian name:_____ Signature:_____

HEALTH HISTORY OF FAMILY MEMBERS

Name _____ Date_____

*The reason for this form is to assist the doctors by providing past or current health history information for their review.

Condition	Self	Father	Mother	Spouse	Brother(s)	Sister(s)	Child(ren)
Allergy/Sinus Trouble							
Arm/Hand/Shoulder Problems							
Arthritis							
Asthma/Emphysema/Lung Dysfunction							
Neck or Back Pain							
Blood Pressure (High or Low)							
Cancer							
Cholesterol							
Constipation							
Diabetes							
Digestion Dysfunction (Acid Reflux etc.)							
Spinal Disc Problems							
Fibromyalgia							
Headaches							
Heart Dysfunction							
Kidney Dysfunction							
Leg/Foot/Hip Problems							
Migraine Headaches							
Muscle Spasms							
Alcohol or Tobacco Use							
Nervousness/Anxiety							
Osteoporosis							
Pinched Nerve							
Scoliosis							
Other (Please Indicate in the space below)							

Description of Other:

_____

_____

NAME: _____ DATE: _____

INFORMED CONSENT FOR CHIROPRACTIC EXAMINATION

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE. I UNDERSTAND AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY.

_____

SIGNATURE OR GUARDIAN SIGNATURE

INFORMED CONSENT FOR OPEN ADJUSTING ENVIORNMENT

CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE IS ADMINISTERED IN A SEMI OPEN ADJUSTING ENVIORNMENT. THIS ALLOWS FOR US TO BE ABLE TO SEE FAMILIES OF ALL SIZES AS WELL AS INDIVIDUALS IN AN OPEN, WELCOMING AND SAFE ENVIORNMENT. I UNDERSTAND AND GIVE CONSENT TO RECEIVE CHIROPRACTIC CARE IN A SEMI OPEN ADJUSTING AREA.

_____

SIGNATURE OR GUARDIAN SIGNATURE

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. IF SPINAL X-RAYS ARE DEEMED NECESSARY BASED ON YOUR INITIAL EXAM THEY WILL BE TAKEN AT OUR OFFICE ON YOUR INITIAL VISIT. BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

_____

SIGNATURE OR GUARDIAN SIGNATURE

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT VERA CHIROPRACTIC.

_____

SIGNATURE

We love to have pictures in our office! If you would allow us to have your picture in the office, please sign below. For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Vera Chiropractic, or anyone authorized by Vera Chiropractic, of any and all photographs/videos which were taken of myself and my child, for the purposes of promotional TV, website, social media, and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of Vera Chiropractic, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentiality, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Vera Chiropractic to share this information via their website and their social media platforms including but not limited to Facebook and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected.

_____

SIGNATURE OR GUARDIAN SIGNATURE

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