Patient Introduction – Child

Date: _____

Name: _____
First Middle Last

Parent/Guardian Name(s):_____

Address: _____

_____

_____PC_____

Telephone: Home:_____ Cell:_____

Mother's name: _____ Work#:_____ Cell#: _____

Father's name: _____ Work#:_____ Cell#:_____

Emergency contact name & number: _____

Ages of siblings: Brothers: _____ Sisters: _____

Alberta Health Care Number:_____

Email:_____

*If you would like to subscribe to our appointment reminders, newsletters, educational and lifestyle information

Birth Date: Month: _____ Day: _____ Year: _____ Age: _____

Family Doctor: _____

Who may we thank for referring you to our clinic: _____

Child & Adolescent Consultation History

Child's Name: _____ **Mom:** _____

Dad: _____

Mainly for Moms:

1. Tell us about your pregnancy

Did you carry to full term? **Y N**

Did you have any complications? **Y N** If yes, please explain: _____

_____

2. Tell us about your delivery and birth of this child:

Did you use a midwife?	**Y**	**N**	Hospital?	**Y**	**N**
Did you have a C-Section?	**Y**	**N**	Were forceps used?	**Y**	**N**
Vacuum Extraction?	**Y**	**N**	Were you induced?	**Y**	**N**
Did you have an Epidural?	**Y**	**N**	Was it a difficult birth?	**Y**	**N**
Did you breastfeed?	**Y**	**N**	How long did you breastfeed? _____ months		

What was the baby's **APGAR** Score initially? _____ At 5 minutes? _____

Tell us more:

During Your Pregnancy, Did you:

Drink Alcohol?	**Y**	**N**	How much? _____	
Smoke Cigarettes?	**Y**	**N**	How much? _____	
Take any Medications?	**Y**	**N**	For what? _____	What type? _____
Consume illicit drugs?	**Y**	**N**	What kinds? _____	
Have Ultrasounds?	**Y**	**N**	How many? _____	

3. Please note any of the following that your child has experienced from birth to now:

___ Played in "Jolly Jumper"	___ Frequent crying/colic	___ Headaches
___ Fall off table/crib/bed	___ Tonsillitis	___ Dizziness
___ Fall off playground	___ Ear Infections	___ Ringing in ears
___ Other significant fall	___ Diarrhea/Constipation	___ Other joint pain
___ Sports accident	___ Frequent fevers/colds	___ Reaction to vaccines
___ Involved in car accident	___ Asthma	___ Hyperactivity/Autism
___ Scoliosis	___ Allergies	___ Learning difficulties
___ "Growing Pains"/leg pains	___ Stomach pains	___ Sleeping Problems
___ Neck/Back pains	___ Bed wetting	___ Other _____
___ Shoulder/Arm/Hand pains	___ Fatigue	_____
___ broken bones	___ car accident	_____

Please explain any of the above: _____

_____

4. List any current medications and their reason: _____

_____

5. List any surgeries: _____

6. Approximate number of times antibiotics have been used: _____

For what reason? _____

7. Is your child following a vaccination program: _____

Has your child had any reaction to the vaccination program? _____

8. ☐ Check here if there are no complaints and are here for Wellness Care. Then skip to #17.

9. **What is the main reason for your appointment?** _____

_____

Is this problem: ___Constant ___Intermittent ___Occasional ___Cyclical

10. **How long has it persisted?** _____

11. **What makes it worse?** _____

12. **What makes it better?** _____

13. **What have you done about it that has NOT worked?** _____

_____

14. **When it is at its worst, how does it make your child feel?** _____

15. **What effect does this problem have of your child's body functions?**_____

_____

16. **What effect does this have on his/her participation in daily activities?**_____

_____

17. **Describe any hospital stays:** _____

18. **Has your child ever received any antibiotics? Y N If yes, how many times and reason** _____

19. **How many hours per day does your child typically spend watching a TV, computer, tablet or phone?** _____

20. **Please list any food intolerance or allergies and when they began**

_____

_____

_____

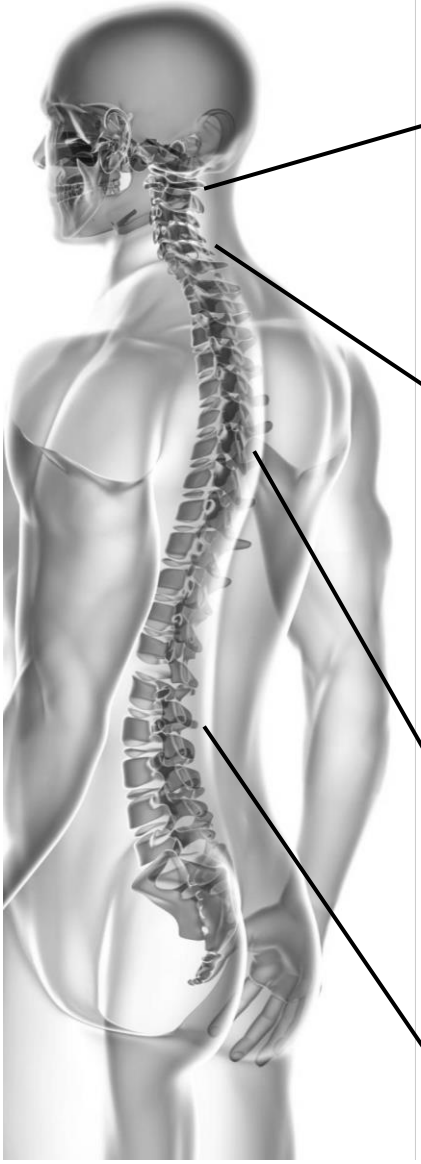
21. **Is there anything else you feel we should know?** _____

_____

The Nervous System (Brain, Spinal Cord and Nerves) sends signals out from different levels of your spine to control specific areas of your body. This system controls everything in your body.

Interference known as a **Subluxation** can cause problems at specific levels of the spine, causing different symptoms.

Are you currently experiencing any of the following issues? **Check all that apply.**



Upper Neck

These Nerves Control:

- Head, Face

- ☐ – Headaches
- ☐ – Dizziness, Lightheadedness
- ☐ – Ringing in your Ears
- ☐ – Face Pain
- ☐ – Vision Problems, such as Floaters
- ☐ – Frequent Sighing

Lower Neck

These Nerves Control:

Thyroid Gland
Vocal Chords
Shoulders
Arms, Hands

- ☐ – Neck/Shoulder Tension
- ☐ – Hands go Tingly/Numb
- ☐ – Fingers Sore/Tight/Swollen
- ☐ – Arm/Fingers Give Out Easily
- ☐ – Anxiety/Depression
- ☐ – Weight Gain/Loss
- ☐ – Hormonal Issues; PMS, Hot Flashes
- ☐ – Difficulty Swallowing
- ☐ – Having to Clear Your Throat in Morning
- ☐ – Lose Pitch When Talking/Singing

Between the Shoulder Blades

These Nerves Control:

- Heart
- Lung
- Stomach

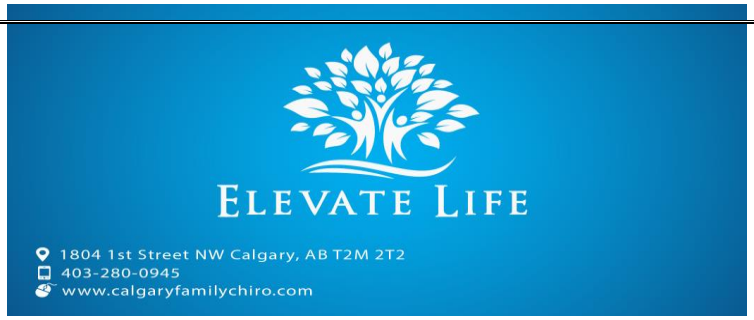
- ☐ – Heart Palpitations
- ☐ – Asthma/Shortness of Breath
- ☐ – Chest Pressure/Pain
- ☐ – Acid Reflux/GERD
- ☐ – Ulcers
- ☐ – Excessive Burping

Low Back

These Nerves Control:

- Sexual Function
- Back, Legs, Feet

- ☐ – Constipation/Diarrhea/Rectal Bleeding
- ☐ – Gas/Bloating
- ☐ – Sexual Difficulties/Fertility Problems
- ☐ – Urinary Problems; Dribbling
- ☐ – Crohn's/Ulcerative Colitis/IBS
- ☐ – Cramping in Legs/Calves/Feet at night
- ☐ – Knee Pain
- ☐ – Cold Feet
- ☐ – Numbness in Feet/Legs



MEDIA RELEASE CONSENT

Purpose of Consent: By signing this form, you are consenting to allow **MONTEREY SQUARE CHIROPRACTIC CLINIC** and any associated staff members to use and distribute your photo along with your patient testimonial. To use and disclose the information you provided in your video consent. Also acknowledge that your testimonial may be distributed to the public.

Right to Revoke: You have the right to revoke this Release at any time by providing written notice of your revocation and submitting it to us. Please understand that revocation of this Release will not affect any action **MONTEREY SQUARE CHIROPRACTIC CLINIC** or his/her staff took in reliance on this Release before receiving your revocation.

I hereby grant permission to allow **MONTEREY SQUARE CHIROPRACTIC CLINIC** to use the photograph of me shown below in conjunction with my patient testimonial. I hereby agree and acknowledge that my photo will be released to the public via public relation efforts of **MONTEREY SQUARE CHIROPRACTIC CLINIC** I further acknowledge and agree that my photo, video, or testimonial may be used by the media.

I waive the right of prior approval and hereby release **MONTEREY SQUARE CHIROPRACTIC CLINIC** from any and all claims for damages of any kind based on the use of my photo,video or information contained in my testimonial.

By signing below I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Release.

_____

Signature and/or Legal Guardian Date

_____

Print Name

I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. _____ (Initials)

I further understand that interest of 2% per month calculated monthly (24% per year compounded monthly) would be charged to any unpaid balance. I agree to pay this interest on any unpaid balance. I further agree to pay for any charges or fees (collection charges or legal fees) incurred in the collection of this account, should that become necessary. _____ (Initials)

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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 <u>NOT</u> 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.

_____ Date: _____ 20____.
Name (Please Print)

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

_____ Date: _____20____
Signature of Chiropractor

Thank You!