PATHWAYS

FAMILY CHIROPRACTIC

Clear

PERSONAL INFORMATION

Name: _____ Preferred Name: _____ Date:_____

Birthday (MM/DD/YY): _____ Age: _____ Gender: Male ○ Female ○

Address: _____

City /Province/ Postal Code: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____ would you like email appointment reminders? Y ○ N ○

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

Sibling: _____ Age: ____ Gender: M ○ F ○ Sibling: _____ Age: ____ Gender: M ○ F ○

WHO MAY WE THANK FOR REFERRING YOU INTO OUR OFFICE?

- ○ Family / Friend (name) _____
- ○ Website / Social Media _____
- ○ Workshop (which group)_____
- ○ Health Practitioner (name) _____
- ○ Student Benefit Program
- ○ Walk - In
- ○ Print Advertisement
- ○ Other _____

CHIROPRACTIC HISTORY

Has your child ever been to a chiropractor before? No ○ Yes ○ Date of last visit: _____

Has a family member previously seen a Chiropractor? No ○ Yes ○ If yes, Parent ☐ Sibling ☐ Child ☐

Name of Chiropractor:_____

Reason for seeing them: _____

Describe your experience: _____

How frequently did you go for adjustments? _____

What made you decide not to return? _____

EXTENDED MEDICAL INSURANCE

Provider_____

Plan holder's Name_____

Plan & ID Numbers _____

*Note: we do not direct bill to insurance companies; however, we will provide you with your coverage amount for chiropractic care.

PREGNANCY HISTORY

Were any supplements taken during the pregnancy? No ○ Yes ○ Which ones? _____

_____

Medications taken during the pregnancy (prescription or over the counter) ? No ○ Yes ○ Which ones? _____

_____

During the pregnancy did the mother:

Smoke? No ○ Yes ○ How much? _____

Drink? No ○ Yes ○ How much? _____

Any Ultrasounds or other radiation? No ○ Yes ○

If so, How many and for what reason? _____

Were there any invasive procedures during the pregnancy (Amniocentesis, CVS, etc.)? No ○ Yes ○

Please explain _____

Trauma / Illness during the pregnancy _____

Please describe any emotional stress the mother experienced during the pregnancy _____

_____

HEALTH TEAM

Name of Obstetrician / Midwife _____ Name of Pediatrician / Family MD _____

Name of Naturopath _____ Other _____

LABOUR AND BIRTH HISTORY

Position during labour? On back ☐ Side ☐ Sitting ☐ Standing ☐

Was Labour induced? No ☐ Yes ☐

Did the mother have an episiotomy? No ☐ Yes ☐

Was monitoring used? Internal ☐ External ☐

Location of birth? Home ☐ Hospital ☐ Birthing Center ☐

Birth assistants? Midwife ☐ Doula ☐ Medical Doctor ☐ None ☐

How many hours did labour last? _____ Birth Weight: _____ Birth Length : _____

Was the mother administered any drugs? Epidural ☐ Morphine ☐ Other _____

Was there any assistance used during birth? No ◯ Yes ◯ Forceps ☐ Caesarean ☐ Vacuum ☐

Was there any evidence of birth trauma to the infant? Check all that apply:

Bruising ☐ Stuck in Birth Canal ☐ Respiratory Depression ☐

Odd Shaped Head ☐ Fast or excessively long birth ☐ Cord around Neck ☐

Were there any other complications during birth or congenital anomalies/defects present? No ◯ Yes ◯

Explain: _____

MEDICAL HISTORY

History of antibiotics? No ◉ Yes ◯ Why? _____

Which ones and how many rounds? _____

Has your child taken prescription medications? No ◯ Yes ◯ Why? _____

Which ones and how many times? _____

Has your child taken over-the-counter medications? No ◯ Yes ◯ Why? _____

Which ones and how many times? _____

Has your child had any surgeries? No ◯ Yes ◯ Why? _____

GROWTH AND DEVELOPMENT

Was child breastfed? No ◯ Yes ◯ For how long? _____

Difficulties with Lactation? No ◯ Yes ◯ Explain: _____

Was Formula introduced? No ◯ Yes ◯ Why? _____

Was cow's milk introduced? No ◯ Yes ◯ At what age? _____

Have solid foods been introduced? No ◯ Yes ◯ At what age?___ 1st foods?_____

Food intolerance? _____

Quality of sleep? Good ◯ Fair ◯ Poor ◯ Number of hours?_____

Did your child favour turning their head to one side during sitting, sleeping or nursing? No ◯ Yes ◯ Left/Right ◯

At what age did your child start: Rolling Over _____ Crawling_____ Walking _____

Describe any complications or delays you noticed: _____

Any falls from couches, beds, changing tables, etc.? No ◯ Yes ◯ _____

Any complications or delays noticed with speech development? _____

HEALTH CONCERNS

Please check all that he/she has experienced in the past 12 months:

- ☐ ADD/ADHD
- ☐ Allergies_____
- ☐ Appetite/Metabolism
- ☐ Autism Spectrum
- ☐ Back Pain (select area)

- ☐ Bedwetting
- ☐ Behaviour Issues
- ☐ Cancer
- ☐ Colic
- ☐ Constipation
- ☐ Cramps
- ☐ Depression/Anxiety
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizziness/Vertigo
- ☐ Ear Infections/Aches
- ☐ Epilepsy/Seizures
- ☐ Gas/Bloating
- ☐ Headaches/Migraines
- ☐ Heart Conditions
- ☐ Neck/Shoulder Pain
- ☐ Nursing Difficulty
- ☐ Plagiocephaly
- ☐ Pneumonia/Bronchitis
- ☐ Reflux/Spit Up
- ☐ Respiratory Issues
- ☐ Sensory Processing
- ☐ Skin issues
- ☐ Sleep Problems
- ☐ Speech Development
- ☐ Throat issues
- ☐ Urinary Tract Infections
- ☐ Walking issues

Other:_____

Special Note: Has your child taken any medication within the last 24 hours? ○ No ○ Yes

Please List: _____ _____

Which one of the above is your main concern and brought you to our office? _____

On a scale of 1 - 10 (10 being severe), how bad is the problem? _____ / 10

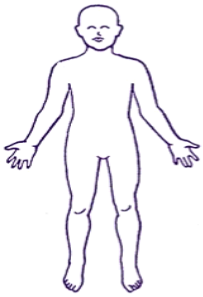
When did it start? _____ How? _____

Is it ? getting better getting worse staying the same

How would you describe the problem? _____

Are you taking medication for this condition? No ○ Yes ○ Please List: _____

Where is the problem? Please circle or draw on the illustrations and explain or describe your present condition in the lines below (i.e. sharp, dull, burning, tight, throbbing…).



Front _____

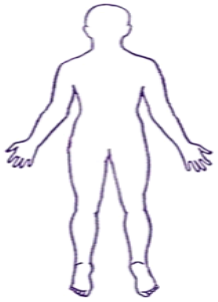
_____

_____

Back _____

_____

_____



What makes it worse? _____

What makes it better? _____

What else have you tried and what were the results? _____

What parts of life is this interfering with?

School_☐_ Play_☐_ Exercise_☐_

Sleep_☐_ Hobbies_☐_ Positive Mental Attitude_☐_

Other:_____

Which part of life is most important to get back to ASAP?_____

Beyond feeling better, what are your top 3 goals for getting healthier?

1)_____

2)_____

3)_____

Fill out ALL detail below for the NEXT 3 most concerning conditions that you checked off on the last page:

#1: _____

On a scale of 1-10 (10 being severe) how significant is the problem? ____ / 10

When did it start? _____ How? _____

Is it? Getting Better___ Getting Worse___ Staying the same___

Describe the problem: _____

Are you taking medication for this condition? No___ Yes___ Please list:_____

#2: _____

On a scale of 1-10 (10 being severe) how significant is the problem? ____ / 10

When did it start? _____ How? _____

Is it? Getting Better___ Getting Worse___ Staying the same___

Describe the problem: _____

Are you taking medication for this condition? No___ Yes___ Please list:_____

#3: _____

On a scale of 1-10 (10 being severe) how significant is the problem? ____ / 10

When did it start? _____ How? _____

Is it? Getting Better___ Getting Worse___ Staying the same___

Describe the problem: _____

Are you taking medication for this condition? No___ Yes___ Please list:_____

Please list ALL OTHER medications your child is currently taking and for what reasons:

_____

PATHWAYS

FAMILY CHIROPRACTIC

Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiroprctic 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**

_____ **_____**