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Date: ______________________________________

Chiropractic Pediatric Intake Form
Pediatric age 0-12

Patient Information

Child's First Name: ______________________________M.I:_______ Last Name: ________________

Preferred Name: ____________________________

Address: ____

City/Province/Postal Code: ____

Birth Date (mm/dd/yyyy) :_____________________ Age: _______ Sex: M F

#of Siblings: ______________________________

Sibling's Name and ages: ____

Parent's Names: ____

Best Contact Phone: ( )_____________________________ Alt. Phone ( )___________________

Email: ____

How did you hear about Calgary Family Wellness?:____

Current Health Condition

Purpose of appointment/current complaint: ____

How/When did current complaint occur:____

Is this complaint (circle): New/reoccurring

Did it come on (circle): Suddenly/gradually/comes & goes

Did and fall, injury or trauma contribute to the current complaint:____

Is your child currently taking medications/or under any other medical care:____

For what conditions: ____

Past Health History

Birth History:

Length of pregnancy: Full Term (weeks)________/early (weeks):____________/late (weeks):________

Any issues during pregnancy for mom/baby: (position of baby, blood pressure etc:)

____

Type of Delivery: (circle) Normal vaginal/Breech/Caesarean invasive procedures: Epidural, Forceps, Vacuum

Length of Labour: ____________________Normal/Difficult Birth Weight: ______________________

Birth Length: _________________________ Congenital anomalies: ___________________________

Health Concerns

❑ Anxiety/ Depression	□ Autism/Asperger's
❑ Constipation/Diarrhea	□ Asthma/Chronic Bronchitis
❑ Nausea/Vomiting	□ Fatigue
❑ Diabetes	□ Irritability/Nervousness
❑ Bed Wetting	□ Colic/Acid Reflux
❑ Overweight	□ Detachment/Distant
❑ Frequent Sickness	□ Back/Neck Pain/Stiffness
❑ ADD/ADHD	□ Difficulty gaining weight
❑ Headaches	□ Ear or other infections
❑ Learning Disorders	
❑ Sinus Troubles/Allergies	
❑ Other_________________	
❑ Other_________________	
❑ Explain any boxes checked	

____
____
____
____
____
____

❑ Is there anything else regarding your child's current condition you feel the Doctor should know?_____________________________________
____
____
____
____

Did you know?...

Each health concern relates to a specific area of the spine and nervous system? Please enter the information to the left

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue / Sleep Problems
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12 L1 L2 L3 L4 L5 SACRAL

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems
Indigestion

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in Legs
Reproductive Problems

Medications/Vitamins & Supplements

❑ Probiotics	❑ Pain Narcotics
❑ Omega-3	❑ Antibiotics
❑ Vitamin D-3	❑ Anti-inflammatory
❑ Digestive Aids	❑ Migraine medication
❑ Multi-vitamin	❑ Asthma medication
	❑ ADD/ADHD medication

- ❑ Other____
- ❑ Explain any checked boxes____
  ____

Lifestyle/ Habits

Did you breastfeed the baby? Yes No If yes, how long: _______

Did you formula-feed the baby? Yes No If yes, how long: ______

At what age did you introduce: Solids: __________ Cow's milk: __________

Does your child exercise daily? Yes No How much?____

Does your child drink soda? Yes No How much/often?____

Does your child have a positive self-esteem or self-image? Yes No

Does your child watch more than an hour of TV per day? Yes No How much?_______________________

Does your child eat balanced meals? Yes No

Does your child experience prolonged sadness? Yes No
Explain:____

Does your child have difficulty sleeping? Yes No Explain:
____

Does your child play video games? Yes No How much?
____

The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs, etc.). Was this the case for your child? Yes No
Explain: ____

Has your child ever been hospitalized or had surgery? Yes No
Explain:____

Does your child have difficulty interacting with others? Yes No
Explain:____

Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Yes No
Explain:

____

Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)? Yes No Please list:

____

Are you aware of any food allergies or intolerance? Yes No
Explain:____
Has your child received all recommended vaccinations? Yes No

Explain: ____

Please rate stress levels on a scale of 1-10 (10 being highest)

School: 1 2 3 4 5 6 7 8 9 10

Personal: 1 2 3 4 5 6 7 8 9 10

Permission to Treat a Minor

I, (Parent/Guardian) ___________________________________, give **Calgary Family Wellness** permission to examine, x-ray (if necessary), and treat ______________________________.

Minor date of birth: ______________________________

Parent/Guardian Signature: ____

Date: _______________

Witness Signature: ____

Terms and Acceptance

When a person seeks chiropractic health care and when a chiropractor accepts a person for such care, it is essential that both are speaking and working for the same goal. The primary goal of chiropractic is

TO LOCATE, ANALYZE, AND CORRECT
SPINAL INTERFERENCE TO THE NERVOUS SYSTEM

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain, and promote health.

I hereby request and consent to the performance of chiropractic procedures including diagnostic x-rays, if necessary, on me by Dr. Shanna Rai and/or anyone working in this clinic authorized by Dr. Shanna Rai.

I will have an opportunity to discuss with the doctor and/or staff, the nature and purpose of chiropractic adjustments and other procedures, as well as any questions I have regarding specific technique performed. I understand that the results expected are not guaranteed, as every person is unique.

I further understand and am informed that, as in all health care, in the practice of manipulation by medical doctors, physiotherapists and chiropractors that there are some very slight and minimal risks to care, including, but not limited to: 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 have read the above consent. I will have an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of present and future care.

I understand that the purpose of today's visit is to determine if I am a candidate for chiropractic care and that I am responsible for any fees agreed upon between myself and the attending doctor. All examination fees will be explained to me before any tests are performed.

______________________________	______________________________
SIGNATURE OF PATIENT (OR PARENT/GUARDIAN)	PRINT PATIENT'S NAME
______________________________	______________________________
DATE SIGNED	WITNESS