



Chiropractic Pediatric Intake Form

Glow Health & Vitality New Practice Member

Today's Date *



Month Day Year

Name *

First Name Last Name

Alberta Health #

Address *

Street Address

City State / Province

Postal / Zip Code

Phone Number *

Area Code Phone Number

Cell phone company

If you choose text reminders

Email *

example@example.com

I like appt reminders by: *

Email
Text

I like receiving clinic updates & newsletters: *

Yes, please!
No, thanks

Date of Birth *



Month Day Year

Gender *

Height *

Weight *

Emergency Contact Name *

Emergency Contact Phone Number *

How did you find about about Glow?

Is this a WCB or MVA claim?

WCB MVA

If a current patient referred you, please include their name.

Current Medical Doctor

Last doctor visit & reason

Briefly tell us what brought you in today:

Have you seen another practitioner for this?

List any and all medications:

Medical doctor, massage, acupuncture, etc.

Date of Onset

Month Day Year



Onset was:

- Sudden
- Gradual
- Associated with an event

Duration of episode(s):

- Minutes
- Hours
- Days
- Months
- Years

Initiating and/or aggravating factors:

Prior occurrence of episode(s):

Relieving factors:

Effects of problems on body function and daily activities:

Birthed at:

- Hospital
- Birthing centre
- Home
- Medical
- Midwife

If birth was assisted:

- Forceps
- Vacuum extraction
- C-section
- Induced labour

Birth weight:

APGAR at birth:

Birth length:

APGAR after 5 minutes:

Duration of birth:

Any medications delivered to mother at birth:

Duration of gestation:

Any birthing complications:

Was infant alert within 12hrs of delivery?

- Yes
- No

If no, please explain:

What age did the following occur:

	Age		Age		Age
Respond to sound		Vocalize		Crawl	
Follow an object		Sit alone		Walk	
Hold up head		Teethe			

Normal sleeping patterns? If no, please explain:

- Yes
- No

Please list any family members with major illnesses:

Was/is baby breast-fed? If yes, for how long? Age formula was introduced & type:

- Yes
- No

Age cow's milk was introduced & solid food: What type of food?

Age baby food was introduced & type: List any food/drink intolerance:

Did mother smoke during pregnancy? Did mother drink alcohol during pregnancy? Did mother take drugs during pregnancy?

- | | | |
|-----|-----|-----|
| Yes | Yes | Yes |
| No | No | No |

List any illnesses mother had during pregnancy: List any supplements taken during pregnancy:

Please list any ultrasounds or invasive procedures:

Any pets at home?	Any smokers at home?	Any vaccinations?	Any antibiotics?
Yes	No	Yes	Yes
No	Moderate	No	No
	Heavy		

Please list any and all vaccinations & antibiotics:

Please list any difficulties with lactation or bonding:

Please list any behavioral difficulties and when they began:

Sleeping difficulties?	When did daycare start?	Does your child seem normal for their age?
No		Yes
Sleep walking		No
Night terrors		
Insomnia	Hours of TV a week:	If no, please explain:
Other		

Please list any trauma/accidents during pregnancy:

Please list any birth trauma:

Bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, etc.

Any major falls?	Any major traumas?	Any hospitalizations?	Any surgeries?
Yes	Yes	Yes	Yes
No	No	No	No

Please list any sports played and frequency:

Weight of backpack:



Canadian Chiropractic Protective Association

Informed 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 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 in to 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 traveling 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 medical 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 and responsible for your care. Inform your chiropractor immediately of any change in your condition.**

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.

Patient's Guardian's Signature

Guardian's Printed Name

Practitioner's Signature

Dated this day of



Month Day Year