Chiropractic Youth 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 *

Shoe Size *

How did you find out about Glow? *

If you were referred by a patient, please include their name.

Is this a WCB or MVA claim?

- Yes
- No

Emergency Contact Name *

Emergency Contact Phone Number *

Current Medical Doctor

Last Doctor Visit & Reason

Briefly tell us what brought you in today:

Have you seen another practitioner for this?

Massage therapist, acupuncture, medical doctor, etc.

Please list all medications:

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 occurence of episode(s):

Relieving factors:

Effects of problems on body function & daily activities:

Normal sleeping patterns?

- Yes
- No

If no, please explain:

Consume dairy?

- No
- Rarely
- Sometimes
- Often

Consume soda?

- No
- Diet
- Regular
- Energy drinks

Drink bottled water?

- Yes
- No

List any food/drink intolerance:

Pets at home?

- Yes
- No

Smokers at home?

- No
- Moderate
- Heavy

Any vaccinations?

- Yes
- No

Any antibiotics?

- Yes
- No

Please list any and all vaccinations & antibiotics:

Behavioral problems?

- ◯ Yes
- ◯ No

If yes, when did they start?

Sleeping difficulties?

- ◯ No
- ◯ Sleep walking
- ◯ Night terrors
- ◯ Insomnia
- ◯ Other

Hours of TV a week:

Hours on PC/phone a week:

Any major falls?

- ◯ Yes
- ◯ No

Any major traumas?

- ◯ Yes
- ◯ No

Hospitalizations?

- ◯ Yes
- ◯ No

Any surgeries?

- ◯ Yes
- ◯ No

Please list any major hospitalizations/surgeries:

Please list any sports played & frequency:

Hours of exercise a week:

Hours of play a week:

Weight of backpack:

Please rate stress level at school:

	0	1	2	3	4	5	
None	◯	◯	◯	◯	◯	◯	Extreme

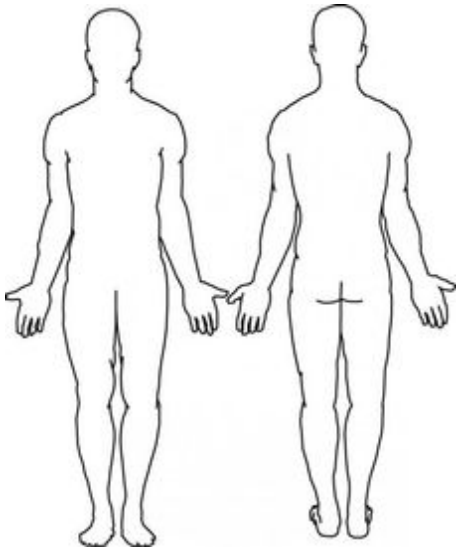
Please rate stress level at home:

	0	1	2	3	4	5	
None	◯	◯	◯	◯	◯	◯	Extreme

What do you do for stress relief?

Any other health habits or needs we should know?

Please list any family members with major illnesses:



Circle or check where you're experiencing discomfort:

- ☐ Head
- ☐ Neck
- ☐ Chest
- ☐ Abdomen
- ☐ Thighs
- ☐ Calves
- ☐ Feet
- ☐ Mid back
- ☐ Arms
- ☐ Jaw
- ☐ Shoulders
- ☐ Ribs
- ☐ Hips
- ☐ Knees
- ☐ Ankles
- ☐ Upper back
- ☐ Lower back
- ☐ Hands

Please select any and all symptoms you've had issues with now or ever:

	Past	Present
Headaches	☐	☐
Neck pain	☐	☐
Back pain	☐	☐
Buzzing in ears	☐	☐
Numbness in fingers	☐	☐
Stomach uset	☐	☐
Irritability	☐	☐
Stiff neck	☐	☐
Diarrhea	☐	☐
Urinary problems	☐	☐
Menstrual pain	☐	☐
Cold sweats	☐	☐
Pins/needles in legs	☐	☐
Pins/needles in arms	☐	☐
Loss of balance	☐	☐
Ringing in ears	☐	☐
Numbness in toes	☐	☐

	Past	Present
Constipation	☐	☐
Heartburn	☐	☐
Menstrual irregularity	☐	☐
Light hurts eyes	☐	☐
Fainting	☐	☐
Loss of smell	☐	☐
Dizziness	☐	☐
Nervousness	☐	☐
Loss of taste	☐	☐
Depression	☐	☐
Sleeping issues	☐	☐
Cold feet	☐	☐
Fever	☐	☐
Mood swings	☐	☐
Ulcers	☐	☐
Fatigue	☐	☐
Tension	☐	☐
Cold hands	☐	☐

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 of 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