Leduc Wellness Centre
Child Chiropractic

Alberta Health Care No: ____ ____ ____ ____ ____ - ____ ____ ____ ____

CONFIDENTIAL PATIENT HEALTH RECORD

Child's Name: _____ Sex: ☐ Female ☐ Male

Address: _____

City/Province: _____ Postal Code: ___ ___ ___ - ___ ___ ___

Telephone: Residence: _____ Cell: _____

Age: _____ Date of Birth: _____ / _____ / _____
yr mm dd

Parent's name: _____

Emergency Contact: _____ Phone: _____

Email (appointment reminders and/or receipts only): _____

Has your child ever received chiropractic care? ☐ No ☐ Yes, if yes:

Where: _____Approx. date of last visit: _____

Is this a Motor Vehicle Accident Case? ☐ No ☐ Yes- Date of Accident? _____

Whom may we thank for referring you to our office? _____

PLEASE READ:

INITIAL VISIT: ADULTS: $90 UNDER 18: $65
PER VISIT FEE: ADULT: $45 UNDER 18: $35

Fees are due at time of service unless other arrangements have been previously made.
A Cancellation Fee may be charged for late or cancelled appointments.

Signature: _____ Date: _____

For dependent children under 18, name of parent(s) /guardian: _____
Parent/guardian with custodial rights must sign.

CHILD HEALTH FORM

To be filled out by parent/guardian.

Child's Name: _____ Parents: _____

Medical Doctor: _____ Last Visit to MD: _____

EVENTS

There are many events that occur throughout childhood- starting with childbirth, then learning how to walk, and playing childhood sports. These events can cause accumulated stress and result in loss of health potential. A child's spine is like a growing tree- "*As the twig is bent, so grows the tree*." Most times the effects on the body are gradual, not even felt until we become adults. Answering the following questions will give us an understanding of your child's overall health and allow us to better assess their body's innate ability to be healthy. Please check ✓ the following.

Tell us about the pregnancy:

Did you carry to full term (40 weeks)? ☐ Yes ☐ If no, how many weeks gestation? _____
Did you consume alcohol during your pregnancy? ☐ Yes ☐ No Did you smoke? ☐ Yes ☐ No
Did you take any medication during your pregnancy? ☐ Yes ☐ No
Medication Details: _____

_____

Describe any complications and when they occurred: _____

_____

Tell us about the labour and delivery of this child:

Did you use a: ☐ Midwife ☐ Obstetrician ☐ Home Birth ☐ Hospital
Did you have a: ☐ C-Section ☐ Vaginal birth
Were you: ☐ Induced ☐ Epidural ☐ Forceps ☐ Vacuum Extraction
What was the baby's **APGAR** Score at 1 minute? ___ /10 & at 5 minutes? ___ /10 OR not sure? ☐
Was there: ☐ Respiratory delay ☐ Purple markings on face ☐ Mis-shaped skull ☐ Jaundice
Describe any problems during labour and delivery: _____

_____

Tell us about your child:

Did you: ☐ Breastfeed How long? _____ ☐ Bottle feed ☐ Formula
Number of hours your child sleeps per night? ____ hrs. Quality of sleep: ☐ good ☐ fair ☐ poor
Was your child vaccinated? ☐ Yes ☐ No List any vaccine reactions: _____
Were you told that you had a choice in vaccinating your child? ☐ Yes ☐ No
List any <u>current</u> medications or supplements your child is taking: _____

_____

List any <u>previous</u> medication(s), for what condition, and the number of times it was prescribed: _____

_____

List any emergency/hospital visits: _____

As a baby/toddler (birth to 4 years), did any of the following occur?

- ☐ Fall from change table/crib
- ☐ Tumble down stairs
- ☐ Involved in a car accident
- ☐ Play in "Jolly Jumper"
- ☐ Fall off playground equipment
- ☐ Constipation
- ☐ Frequent ear infections
- ☐ Reaction to vaccination
- ☐ Bed wetting
- ☐ Frequent fevers
- ☐ Frequent bouts of diarrhea
- ☐ Did not gain weight
- ☐ Sleeping problems
- ☐ Frequent colds
- ☐ Colic
- ☐ Other_____

As a young child (5-12 years), did any of the following occur?

- ☐ Fall from tree/playground equipment
- ☐ Fall off a bicycle
- ☐ Sports accident
- ☐ Car accident
- ☐ Stomach pains
- ☐ Scoliosis
- ☐ Learning difficulties
- ☐ Bed wetting
- ☐ Hyperactivity/Autism
- ☐ Asthma
- ☐ Allergies
- ☐ Leg/knee pains
- ☐ Frequent colds
- ☐ Other_____

SYMPTOMS AND ILL HEALTH

As a child or adolescent, has your child experienced any of the following?

- ☐ Headaches
- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Asthma
- ☐ Hyperactivity
- ☐ Weight gain/loss
- ☐ Arm/wrist pains
- ☐ Neck/back pains
- ☐ Sleeping problems
- ☐ Allergies
- ☐ Stomach problems
- ☐ Other: _____
- ☐ Foot/ankle/knee pains
- ☐ Tingling in arms/legs
- ☐ Shoulder pains
- ☐ Fatigue
- ☐ "Growing Pains"

Reason for consulting our office:

- ☐ Health and/or spinal check-up?
- ☐ Correction and/or prevention of an existing problem? *Please fill out the information below.*

If your child has symptoms or a complaint, briefly describe the problem here. _____

_____

How and when did this problem start? _____

The problem is: ☐ Constant ☐ Comes & Goes ☐ Radiates/Travels *(where?)* _____

If s/he is experiencing pain, is it: ☐ Sharp ☐ Throbbing ☐ Aching ☐ Shooting ☐ Nagging

What aggravates the condition / pain? _____

What relieves the condition / pain? _____

Please describe any past or current treatment(s) and results: _____

_____

Is there anything else you would like us to know? _____

Should your health benefit company contact us to confirm treatment dates may we give them that information? ☐ Yes ☐ No Please Initial_____

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 NOT 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