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INITIAL CONSULTATION FORM (CHILD)

PERSONAL INFORMATION Today's Date (M/D/Y) _____

Name _____ (M / F) Birth Date (M/D/Y) _____ Age _____

Phone (please circle preferred contact) H _____ W _____ C _____

Address _____ City _____ Province _____ Postal Code _____

Email _____ Height _____ Weight _____

Referred to this office by _____ Insurance other than OHIP? _____

How many siblings _____

FAMILY HEALTH VALUES

Which of the following *best* describes your family health values (please circle one)

Treatment Only
I only consult a doctor when I have an ache or pain and discontinue care as soon as the ache or pain is relieved.

Preventative Care
In addition to symptomatic care, I occasionally consult specialists to prevent problems from occurring.

Health Maintenance
I am conscious about my health, diet and exercise, etc. and actively pursue these because I feel better, perform better, and it maximizes my potential.

Family Health
I take an active part in assisting, informing, and maintaining health with my family. I am concerned with the long term benefits of good health.

CURRENT HEALTH CONDITION

	Main Complaint(s)	How Severe (1-10)	How Long	Previous Care (Y/N)
1				
2				
3				

On a scale of 0-10 what is your commitment to correcting these problems (0 being none, 10 being full)? _____

What do you believe caused this? _____

Was this caused by a motor vehicle accident? Yes / No Has the child missed any school due to this? Yes / No

Are you content with the child's overall health? Yes / No Explain _____

LIFESTYLE

Exercise/Activity Y / N _____ days/week Amount of Screen Time _____ hours/day

Junk or Fast Food Y / N _____ times/week

PREGNANCY AND DELIVERY

Was a Midwife, Medical Doctor or both utilized during the pregnancy and delivery? _____

What was the child's weight and length at birth? Weight _____ Length _____

How many ultrasounds were performed? _____ Was the mother induced? Yes / No

Were medications used during pregnancy? Yes / No If yes, list: _____

Were medications used during labour/delivery? Yes / No If yes, list: _____

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Was the delivery vaginal or by C-section? _____ If C-section, was it: planned / emergency

Were any of the following used during delivery? (please circle) forceps vacuum other _____

Were there any complications during delivery? Yes / No If yes, please explain _____

At anytime during the pregnancy was the child in an intra-uterine constraining position such as: (please circle)

Breech Transverse lie (side lying) Face/brow presentation

Location of birth: (please circle) hospital birth centre home

CHILDHOOD

Was the child breast fed? Yes / No How many months? ____

Was the child formula fed? Yes / No When was it introduced? ____ Type? _____

When was the child introduced to solids: ____ months cows milk: ____ months

Has the child ever been seen on an emergency basis? Yes / No If yes, explain_____

Has your child received vaccinations? Yes / No

The following times are when the child's spine is the most vulnerable to stress and should have their spine health checked by a Doctor of Chiropractic. At what age was the child able to:
Hold head up: ____ Sit up: ____ Cross crawl: ____ Walk alone: ____

HEALTH HISTORY FORM

Please check if your child is suffering from, previously suffered from or you are concerned they suffer from any of the following:

Ear infections ____
Asthma ____
Allergies ____
Colic ____
Headaches ____
Scoliosis ____
Digestive problems ____
Growing pains ____
Back pain ____
Seizures ____
Sinus problems ____
Eczema/skin problems ____
Constipation/diarrhea ____
Attention problems (ADD/ADHD) ____
Chronic colds/flu ____
Recurring fevers ____
Neck pain ____
Bed wetting ____
Temper tantrums ____
Bronchitis ____
Upper respiratory infections ____
Other _____

Has the child been treated by a medical doctor for any condition in the past 12 months? Yes / No If yes, please list reasons_____

List any medication or drugs your child is currently taking _____

List any vitamins, supplements and/or minerals your child is currently taking _____

Has the child been on any medications for an extended period of time (current or past)? Yes / No If yes, please list _____

How many doses of antibiotics has the child taken? Within 6 months ____ In their lifetime ____

How many doses of other medications has the child taken? Within 6 months ____ In their lifetime ___

Falls and Accidents _____

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All Surgery and Operations _____

Surgery recommended but not performed _____

Has the child ever fallen from a high place? (bed, change table, sofa, stairs, etc) Yes / No If yes please explain:

_____

Has the child been involved in a motor vehicle accident? Y / N If yes, please explain:_____

Has the child ever participated in any impact or contact sports? (soccer, football, gymnastics, hockey etc) Y / N If yes, please explain _____

Has your child ever experienced any of the following illnesses? If yes, at what age?

Chicken pox Yes / No age ____ Mumps Yes / No age ____ Rubella Yes / No age ____

Whooping cough Yes / No age ____ Rubeola Yes / No age ____ Other Yes / No age ____

Family health conditions or problems (please list) _____

Is there anything else you feel we should know about the child's health? If so, please explains _____

_____

_____

Signature: _____Date:_____

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Informed Consent for Chiropractic Care

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;

There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic care, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

_____
Patient Signature (Guardian)

Name: _____
(please print)

_____
Witness of Signature

Name: _____
(please print)

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Consent for Use or Disclosure of Health Information

We, at the Clarity Chiropractic, are very concerned with protecting your privacy. While the law requires us to give you a copy of our privacy notice, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:
We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, and/or treatment of your health condition.
We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
We may need to use your health information within our practice for quality control or other internal operational purposes.

You have the right to request that we do not disclose your health information to specific individuals, companies, and/or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

You may revoke any of your authorization at any time; however, your revocation must be in writing. We will not be able to honour your revocation request if we have already released your health information before we receive your request to revoke your authorization.

I have read your consent policy and agree to its terms.
I am requesting a copy of this consent form [ ]
I am not requesting a copy of this consent form [ ]

_____ _____

Signature of Patient Signature of Witness

_____ _____

Date Date