Company logo and basic contact details (phone, email website) go here
Contact CCAA if you need assistance

Chiropractic New Patient Form – Infant / Child

Patient Information (please print clearly)

Name: ____ Date of Birth: dd/mm/yyyy ____/____/_______

Height/length: ______ Weight: ______ Family Doctor: (name) ______________(number)______________

Name of parents/guardians: ____

Primary Address:_________________________________ City:_______________ Postal Code:_________

Phone: (H) _______________________ (B)_______________________ (M)________________________

Email address: ____

How did you find out about us? ________________ If online, what site referred you? _________________

Emergency Contact: (Name) _________________ (Relationship) _________ (Phone number) __________

What is your reason for bringing your child into our office today? ________________________________

____

What goals would you like to achieve for your child's health? ____________________________________

____

On a scale of 1 – 10 Rate your level of commitment to helping your child achieve these health goals:
1 Low - 2 – 3 - 4 - 5 – 6 – 7 - 8 – 9 - 10 Very High

Previous chiropractic care? ______ Dr.'s name/last visit ____

Describe the care your child received ____

If your child is not experiencing symptoms and you simply request wellness services please check here __ and skip to the next section. If there is a specific health concern please answer the following questions:

Describe the nature of your child's symptoms or health concern:

1. ____
2. ____
3. ____

When did this problem start? _____________________ How did it start? ___________________________

Child's Health History

Please provide an overview of your child's health history:

Previous fractures, surgeries, or hospitalizations (Please list and date): ______________________________________

____

<table>
<tr><th colspan="3">Birth Details:</th></tr>
<tr>
<td>❑ Hospital
❑ Birthing Centre
❑ Home
❑ Medical
❑ Midwife
❑ Normal Delivery
❑ Assisted Delivery
If yes:
❑ Forceps
❑ Vacuum extraction
❑ C-section
❑ Induced labour</td>
<td>Duration of gestation: _____wks

Duration of birth: _______hrs

Medications delivered to mother during labour: _______________
____

Birth Weight: ________
Birth Length: ________

APGAR: _____(birth) ______(5 min)</td>
<td>Describe any complications at birth:</td>
</tr>
</table>

<table>
<tr><th>Growth and Development</th><th colspan="2">Chemical Stressors</th></tr>
<tr>
<td>At what age did the child:
Respond to sound? ___________

Follow an object? ____________

Hold up head? _______________

Vocalize? __________________

Sit alone? __________________

Teethe? ____________________

Crawl? _____________________

Walk? ______________________</td>
<td>Was the child breast fed? ______
If yes, for how long? __________

Any food/juice intolerance? ____
____
____
____

Did mom smoke while pregnant?
❑ Yes
❑ No
Did mom drink while pregnant?
❑ Yes
❑ No
Did mom have any illness while pregnant?
____

Did mom take any meds or supplements during pregnancy? ____________________
____

Any invasive procedures during pregnancy? (e.g. amnio, U/S) ______________________

Any pets/smokers in the home? _________</td>
<td>Describe any vaccinations and whether any negative reactions occurred:

Describe number and type of medications (including antibiotics) and for what reason:</td>
</tr>
</table>

Psychosocial Stressors	Traumatic Stressors	
Any difficulties with location? __ ____________________________ Any difficulties with bonding? __ ____________________________ Any night terrors, sleep walking, difficulty sleeping? ___________ ____________________________ ____________________________ Age of child entering daycare? __ ____________________________ Average number of hours of television per week ___________ Does child seem normal for age? ____________________________ ____________________________ ____________________________	Any traumas during pregnancy? (e.g. falls, accidents) __________ ____________________________ ____________________________ Any evidence of birth trauma/ (e.g. bruises, odd shaped head, stuck in canal, long/short birth, cord around neck, respiratory depression) _________________ ____________________________ ____________________________ ____________________________ Any falls from couches, beds, etc? ________________________ ____________________________ Weight of school backpack? ____ Approximate hours per week spent at play? ________________	*Describe any behavioural problems and age of onset:* *Describe any additional concerns:*

Please indicate if your child has experienced any of the following conditions currently **(C)** or in the past **(P)**.

Measles	C or P	Seizures	C or P
Chicken Pox	C or P	Scarlet Fever	C or P
Mononucleosis	C or P	Colic/Gas/Cramping	C or P
Mumps	C or P	Diarrhea	C or P
Ear Infections	C or P	Digestive difficulties	C or P
Pneumonia	C or P	Constipation	C or P
Headaches	C or P	Frequent colds	C or P
ADD/ADHD	C or P	Coughing/Wheezing	C or P
Rubella	C or P	Sinus problems	C or P
Asthma	C or P	Cold sores	C or P
Hives/Rashes/Eczema	C or P	Strep throat/Tonsillitis	C or P
Allergies	C or P	Chronic runny nose	C or P
Hay fever	C or P	Anxiety	C or P
Temper tantrums	C or P	Bed wetting	C or P

Informed Consent to Chiropractic Adjustments and Care

Chiropractors locate, analyze and correct *subluxations* (spinal misalignments which cause nerve interference). Chiropractic improves the nerve supply to your entire body and allows the *innate healing power of your body* to work at maximum efficiency to restore, maintain and promote health.

Chiropractic care is considered to be one of the safest and most effective forms of health care. As in all health care, however, there are some slight and minimal risks to chiropractic care, including but not limited to, minor muscle strains and sprains, disc injuries and strokes. Tests will be performed on you to minimize this risk and the appropriate chiropractic adjusting techniques will be applied.

The doctor and/or staff will always be available to answer questions and discuss the nature and purpose of chiropractic procedures. Results cannot be guaranteed, as every person is unique.

Informed Consent to Chiropractic Adjustments and Care

"I have read the above and wish to rely on the doctor to exercise judgement during the course of my care which the doctor feels at the time, based on the facts then known, is in my best interest. I intend this consent to cover the entire course of treatment, including any x-rays that may be required, for my present condition and for any future condition(s) for which I seek treatment."

________________________ __________________________ ____________________
Patient's Name Parent or Guardian Signature Date

Disclosure of Personal Health Information

Please know that we are very concerned with protecting the privacy of your personal health information. While the law requires us to notify you about this disclosure, please understand that we have, and always will, respect the privacy of your health information. However, please be advised that it my be necessary for us to disclose your health information to another health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. I have read the above privacy pledge and agree to its terms.

Patient or Guardian Signature _______________________________ Date ____________