

ABERFOYLE FAMILY CHIROPRACTIC

"Natural Care for all ages"

Paediatric In-Take Form (infant to age 16)

Patient Name: _____ Date: _____

Address: _____ City _____ Postal Code _____

Tel: Home _____ Work _____ Cell _____ Email _____

Date of Birth: ____ / ____ / ____ Gender: M F Height cm in Weight kg lb
Month Day Year

Have you consulted other health care professionals for this problem? Yes No

If Yes, please list: _____

Other health problems: _____

Please check the conditions for which your child has been treated:

- | | | |
|---|--|--|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Recurring Fevers |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Back Pains | <input type="checkbox"/> Neck Pains |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Seizures | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Sinus Troubles | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Eczema/Skin Problems | <input type="checkbox"/> Bronchitis/Upper Respiratory Infections |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Attention Problems – ADD/ADHD |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Other (Specify) _____ |

Are you content with your child's present level of health: Yes No

Please Explain _____

Previous Chiropractor: _____

Reason for Visits: _____

Has your child been treated by a physician for any condition in the previous 12 months? Yes No

If yes, please explain: _____

Is your child currently taking any medication? Yes No

If yes, please list along with reason. _____

Has your child taken any medication for an extended period of time in the past? Yes No

If yes, please list along with reason. _____

Does your child take any herbal or vitamin supplementation? Yes No

If yes, please list. _____

Number of doses of antibiotics your child has taken:

During the past 6 months: _____ During his/her lifetime: _____

Number of doses of other prescription medications your child has taken:

During the past 6 months: _____ During his/her lifetime: _____

Name of Midwife/Obstetrician: _____ Ultrasounds during pregnancy? Yes No

ADDITIONAL INFORMATION

Medications during pregnancy? Yes No

Medications during labour/delivery? Yes No

If yes, please list: _____

Were you induced? Yes No

Was your child at any time during your pregnancy in an intra-uterine constraining position, such as:

Breech Transverse Lie (side lying) Face/Brow Presentation

Was your delivery vaginal? Yes No

Was your delivery C-Section? Yes No If so, was it planned or emergency? Planned Emergency

Were any of the following used during delivery? Forceps Vacuum Extraction Other

If "Other", list: _____

Any complications during delivery? Yes No

If yes, please explain: _____

Location of birth: Hospital Birth Centre Home

Weight: _____ kg lb Length: _____ cm in

Breast fed: Yes No If yes, how many months? _____

Formula fed: Yes No If yes, what type? _____

Introduced to solids at: _____ months Cow's milk at: _____ months

Food sensitivities: _____

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

At what age was your child able to; Hold head up:___ Sit up:___ Cross Crawl:___ Walk alone:_____

Has your child ever fallen from a high place? (bed, change table, sofa, down stairs, etc.) Yes No

If yes, please explain: _____

Is/was your child involved in any impact or contact sports? (soccer, football, gymnastics, baseball, roller or ice hockey)

Yes No If yes, please explain: _____

Has your child ever been involved in a car accident? Yes No

If yes, please explain: _____

Has your child ever been seen on an emergency basis? Yes No

If yes, please explain: _____

Other traumas? Yes No

If yes, please explain: _____

Prior Surgery? Yes No

If yes, please explain: _____

ADDITIONAL INFORMATION

Has your child received vaccinations? Yes No

Does your child exercise? Yes No

What type of exercise: _____

Please indicate whether your child has experienced any of the following illnesses, and if so, at what age:

- Chicken Pox Age: _____ Mumps Age: _____ Rubella Age: _____
- Whooping Cough Age: _____ Rubeola Age: _____ Other Age: _____

If "Other", please list: _____

Additional Comments: _____

Consent for Care

Our Clinic is dedicated to assisting you in recovering your health naturally. Please review the next paragraph and sign in the area provided.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and I am responsible for payment to the Doctor. All fees are due at time of service.

I hereby request and consent to the performance of Chiropractic examinations, adjustments and other chiropractic procedures such as but not limited to orthotics, Spine-Force and Creating Wellness, and if necessary, diagnostic x-rays on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor of chiropractic/staff members named below and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic, there are some very slight risks to treatment, including but not limited to, muscle strains and sprains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read the above Consent. I have also had an opportunity to ask questions about it's content and by signing below, I agree to the above mentioned chiropractic procedure. I intend this Consent Form to cover the entire course of treatment for my present condition.

Signature of Parent or Guardian: _____ Date: _____

On Behalf of: _____ Age: _____
Please print name of child

**Aberfoyle Family Chiropractic,
32 Brock Rd. N.,
Guelph, Ontario. N1H 6H9**

Dr. Peter Fraser