

CONFIDENTIAL PATIENT INFORMATION SHEET
Please complete FULLY and accurately

NP # _____

PERSONAL HISTORY

Name: _____ Date of birth: _____ Age: _____
Address: _____ City: _____ Postal code: _____
Tel: Home _____
Mother's Name: _____ Father's Name: _____
Family Dr (Name & Tel.): _____
Emergency contact (Name, Tel. & Relationship): _____

How were you referred to this clinic?

WHY IS THIS FORM IMPORTANT?

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

HEALTH PROFILE

If your child has no systems or complaints, and is here for wellness services, please check .

Others need to briefly describe the chief complaint, including the effect it has on the child.

If he/she is experiencing pain, is it Sharp Dull Comes and Goes Travels Constant

Since the problem started, is it About the same Getting better Getting worse?

What makes it worse? _____

It interferes with: School Sleep Walking Sitting Hobbies Other: _____

Other Health Professionals seen for this problem:

Chiropractor: _____

Medical Doctor: _____

Other: _____

List medications the child is taking or surgeries the child has had:

Daily, we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that allow us to better assess the challenges to your child's health potential.

PREGNANCY

Where there any complications to the pregnancy? _____

Was Mom on any medications, prescription or over-the counter? Yes No

If yes, explain: _____

Did Mom or Dad smoke during pregnancy? Yes No Who? _____

Was the baby ever in the Breech position? Yes No

How many ultrasounds were performed? _____

BIRTH & DELIVERY

Where was the baby born? Home Hospital Birthing Center Other: _____
 Was the delivery: Vaginal C-Section were devices used? Forceps Vacuum
 How long was the labor? _____ How long was the delivery? _____
 Was Oxytocin/pitocin used? Yes No Was an epidural administered? Yes No

INFANCY

Was the infant vaccinated? Yes No
 Was there any prolonged use of medicines or an inhaler? Yes No
 If yes, which _____
 Did the infant suffer any traumas such as serious falls or car accidents? Yes No
 Has the infant been under regular chiropractor care? Yes No

CHILDHOOD YEARS

Did the child have any childhood illnesses? Yes No Explain: _____
 Does the child play youth sports? Yes No Which Sport _____
 Has the child had any surgery? Yes No Explain: _____
 Has your child fallen from a height of over 3ft? Yes No Explain: _____

Was your child involved in any car accidents? Yes No When? _____
 Has there been any prolonged use of meds? Yes No Explain: _____
 Has the child suffered any emotional traumas? Yes No Explain: _____
 Please give us any other health information you feel would be helpful: _____

FAMILY HEALTH HISTORY

Have you or anyone in your family had the following (specify whom):

Heart disease _____ High blood pressure _____
 Cancer _____ Diabetes _____
 Stroke _____ Other diseases _____

OUR FEES

Type of appointment	Adults	Seniors (65+), Students	Children (<5yrs)
Initial visit	\$75	\$60	\$50
Subsequent chiropractic visit	\$32	\$29	\$24
Subsequent acupuncture visit	\$40	\$40	
Subsequent visit with chiro/acu	\$48	\$45	
Orthotics with Gait Analysis	Regular - \$400; shoes - \$500		

****PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.**

Payment can be made by cash, cheque, debit, VISA/MC. If you cannot attend an appointment, please give **24 HOURS NOTICE** so that another patient may receive care during that time. I have read the above and understand that I am responsible for all charges relating to my visit.

Date: _____

Signature: _____

INFORMED CONSENT

Doctors of Chiropractic and Medical doctors who use manual therapy techniques such as spinal adjustments and manipulations are required to advise patients that there are some risks associated with such treatment. In particular, you should note:

While rare, some patients have experienced muscle strain, ligamentous sprain and rib fracture following spinal adjustments or manipulation.

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 sometime causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical adjustment is extremely remote.

There have been rare reported cases of disc injuries following neck or low back spinal adjustment or manipulation. However, scientific study has not supported that such injuries are caused, or may be caused, by spinal adjustments or Chiropractic treatment.

Chiropractic treatment, including spinal adjustment or manipulation, has been the subject of government reports and multi-disciplinary studies conducted over many years. These reports and studies have demonstrated Chiropractic treatment to be effective for spinal pain, headaches and other similar symptoms. Chiropractic care may contribute to your overall well-being. The risk of injuries or complications from Chiropractic treatment is substantially lower than that associated with other treatments, medications and procedures given for the same symptoms.

I acknowledge, I have discussed or have had the opportunity to discuss, with Dr. McDonald the nature and purpose of Chiropractic treatment in general and my treatment in particular as well as the contents of the consent. I consent to the Chiropractic treatment offered or recommended to me by Dr. McDonald, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Date _____

Print patient/guardian name

Signature of patient/guardian

Print name of witness

Signature of witness

ACUPUNCTURE

I understand and am informed that in the practice of Acupuncture there are risks to treatment. These include but are not limited to minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, possible perforation of organs and stuck or bent needles. I have been advised that only pre-sterilized single use needles will be used.

Date _____

Print patient/guardian name

Signature of patient/guardian