Live Life Better
MEMORIAL DRIVE CHIROPRACTIC & MASSAGE

CHILD/ADOLESCENT CONSULTATION ADMITTANCE FORM

213, 5271 Memorial Drive SE
Calgary, AB T2A 4V1
403 273-0203

Date: _____Alberta Health Care #:_____

Last Name: _____First Name: _____ Mom Name: _____ Dad Name: _____

Address: _____City_____

Postal Code: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____Email: _____

Present Medical Doctor : _____

Date of Birth: _____(year) / _____ (month) / _____ (day)

Health History Part 1:

Chief Concerns: _____

_____

Reason for contacting us: _____

_____

List other care undergone for this complaint (including medications: _____

_____

Date of onset: _____ (yr.)/_____ (m)/_____ (d) Onset was: Sudden / Gradual / Associated with an Event

Duration of problem (episode): minutes / hours / days / months / years

Has this situation or concern: _____ gotten worse _____stayed constant _____ comes and goes

Does it interfere with: _____ sleep _____ school _____ play _____ social functioning _____ other activities?

What activities make the condition better? _____

What activities make the condition worse? _____

Please note any of the following that your child has experienced from birth to now:

___ Played in “Jolly Jumper”
___ Fall off table/crib/bed
___ Fall off playground
___ Other significant fall
___ Sports accident
___ Involved in car accident
___ Scoliosis
___ “Growing Pains”/leg pains
___ Neck/Back pains
___ Shoulder/Arm/Hand pains
___ Frequent crying/colic
___ Tonsillitis
___ Ear Infections
___ Diarrhea/Constipation
___ Frequent fevers/colds
___ Asthma
___ Allergies
___ Stomach pains
___ Bed wetting
___ Fatigue
___ Headaches
___ Dizziness
___ Ringing in ears
___ Other joint pain
___ Reaction to vaccines
___ Hyperactivity/Autism
___ Learning difficulties
___ Sleeping Problems
___ Other _____

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Other health concerns: _____

Date of last MD visit and reason: _____

Present length/height: _____ Present weight: _____

Please note which vaccinations your child has received

- ☐ MMR
- ☐ DPT
- ☐ Chicken Pox
- ☐ Polio
- ☐ Hemophilus influenza B
- ☐ Hepatitis B
- ☐ Other _____

Has your child undergone long term Antibiotic Use: ☐ Yes ☐ No
If yes, please explain: _____ Total # courses of antibiotics to date_____

Has your child experienced any childhood illness or disease? ☐ Yes ☐ No, Explain _____

Chiropractors can help with concerns related to many types of stressors, so following is also important to us:

Chemical and Environmental Stressors

Do you have any pets at home? ☐ Yes ☐ No, If yes, please explain: _____

Does anyone smoke inside of the home with the children present? ☐ Yes ☐ No

Physical Stressors

Has your child ever undergone surgery? ☐ Yes ☐ No

If yes, please explain: _____

Has your child ever been **hospitalized**? ☐ Yes ☐ No

If yes, please explain: _____

Sports played and age began: _____Hours per week played: _____

Does your child participate in any activities which require prolonged, awkward or repetitive postures? (I.e. violin, gymnastics) If yes, please explain: _____

Was your child's birth **traumatic**? ☐ Yes ☐ No

☐ Drug Induced ☐ Forceps or Suction ☐"C" Section ☐ Cord around neck ☐ Breech ☐ Prolonged
☐ Natural ☐ Other: _____

Has your child ever broken **any bones**? ☐ Yes ☐ No

If yes, please explain: _____

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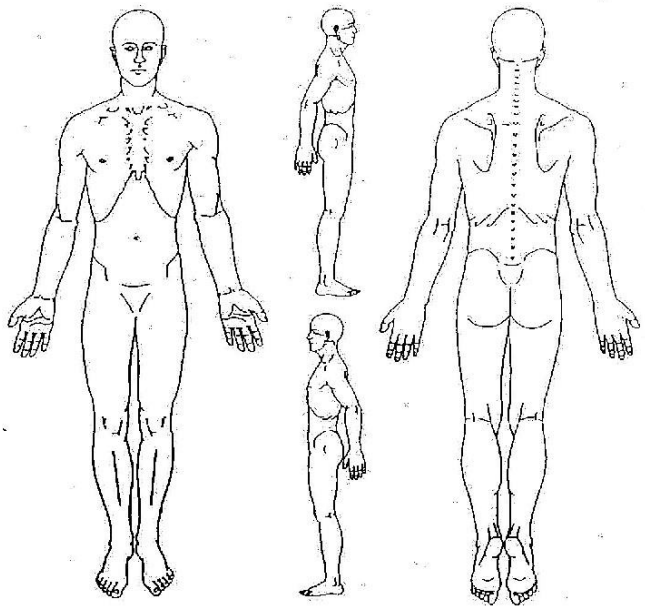
USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATIONS OF SENSATIONS RIGHT NOW

KEY: **A** = ACHE **B** = BURNING **N** = NUMBNESS
P = PINS & NEEDLES **S** = STABBING **O** = OTHER



Psychosocial Stressors

Does your child have any problems with bonding? ☐ Yes ☐ No _____

Any behavioral problems? ☐ Yes ☐ No

If yes, please explain: _____

Any night terrors, sleep walking, difficulty sleeping? ☐ Yes ☐ No Specify: _____

Has your child experienced any of the following? Nightmares / insomnia / sleep walking / bed wetting / teeth grinding

Age of child when began daycare: _____ Average number of television hours per week: _____

Does your child's social and emotional development seem normal for their age? ☐ Yes ☐ No If no, please explain:

_____

_____

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Thank you for completing this form. Please write any other questions you have below:

_____

_____

_____

_____

_____

Thank you for choosing our Chiropractic office.
We are looking forward to helping you to be successful in your ability to develop a healthy spine and nervous system.
We are excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.

Authorization for Care of a Minor

Parent(s) Name(s):_____

Address (If different from Child's):_____

Home phone (If different from Child's):_____ Work phone: _____

I hereby authorize and consent to the Doctors of this clinic and their designated representatives to provide necessary Chiropractic Care including Health History Consultations, Treatments, X-rays, and/or other Procedures. I confirm that I am the custodial parent who has the legal authority to consent to the above.

_____ X_____

Print Name Signature

_____ _____

Date Witness

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

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 the 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 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 disk** – 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 degenerate 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 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 to 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 traveling 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

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towards 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 a stroke.
The consequences of a stroke can be 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 you care. Inform your Chiropractor immediately of any change in your condition.

DO NOT SIGN 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.

_____
Name (Please Print)

_____ Date: _____20 _____
Signature of patient (or legal guardian)

_____ Date: _____20 _____
Signature of Chiropractor