CHILDREN'S PERSONAL HEALTH PROFILE

Appleview Chiropractic Clinic
686 Appleby Line, Unit C3, Burlington ON L7L 5Y3
Phone: 905-639-0073 email: appleviewchiro@gmail.com

Date:	First Name:		Last Name:	
Home Address:			City:	Postal Code:
Mother's Email Address:		Father's Email Address:		
Home Phone: ( )		Mother's Cell Phone: ( )	Father's Cell Phone: ( )	
Gender: ❒ M ☐ F	Height (feet, inches):	Weight (pounds):	Date of Birth: DD MM YY	Age:
Extended Health Insurance (EHI): ☐ No ☐ Yes Company:		EHI $ Participation / Year: Is this amount ☐ per person or ☐ for the entire family?		EHI Renewal Date:
How were you referred to our office?		Have you ever received chiropractic care before? ☐ No ☐ Yes Date of last visit? Who was the Doctor? Years under care? Where was the Doctor?		
Parents'/Guardians' Names:				

Please take a moment to complete the following questions that are designed to maximize your child's health. Many types of stress (physical, mental, chemical) can interfere with your child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please remember to ask questions.

1. Is this visit for a wellness checkup and prevention or a specific concern? _____

   If there is a specific concern please describe:
   _____

2. Circle Appropriately:
   Birth Place: Home / Hospital Type: Vaginal / C-Section / Breech

   Procedures: Forceps / Vacuum Extraction / Induced / Other _____
3. Which Contact sports does your child participate in? Circle Appropriately:
   Soccer / Football / Gymnastics / Karate / Hockey / Basketball / Dance / Other:
   _____

4. According to the National Safety Council, approximately 50% of infants fall from a high place (bed, changing table, etc.) during their first year of life. Has this happened to your child? ❒ Yes ❒ No

5. In your child's whole life, what were his/her 5 most serious physical traumas/stresses (eg. automobile jarring/impacts, school stress, recreational activities, sports, falls)

Trauma	Date of trauma
1)	
2)	
3)	
4)	
5)	

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6. Check any of the following conditions your child has suffered from during the past year:

❒ Ear Infections	❒ Scoliosis	❒ Seizures	❒ Chronic Colds	❒ Headaches
❒ Asthma/Allergies	❒ Digestive Problems	❒ ADHD	❒ Recurring Fevers	❒ Temper Tantrums
❒ Growing or Back Pains	❒ Colic	❒ Bed Wetting	❒ Car Accident	❒ Other _____

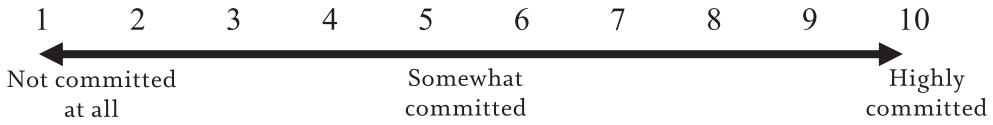
7. How many prescriptions of antibiotics has your child taken in the last year? _____

   Estimate how many in your child's lifetime: _____

8. How many other prescription or over the counter medications has your child taken in the last year? _____

   Please name them: _____

On a scale of 1 to 10 (10 being the highest), rate your commitment if chiropractic care can help correct this problem or prevent future health problems *(circle number)*:



What did you like the MOST about your previous experience with your Doctor of Chiropractic/Medical Doctor?

_____

What did you like the LEAST about your previous experience with your Doctor of Chiropractic/Medical Doctor?

_____

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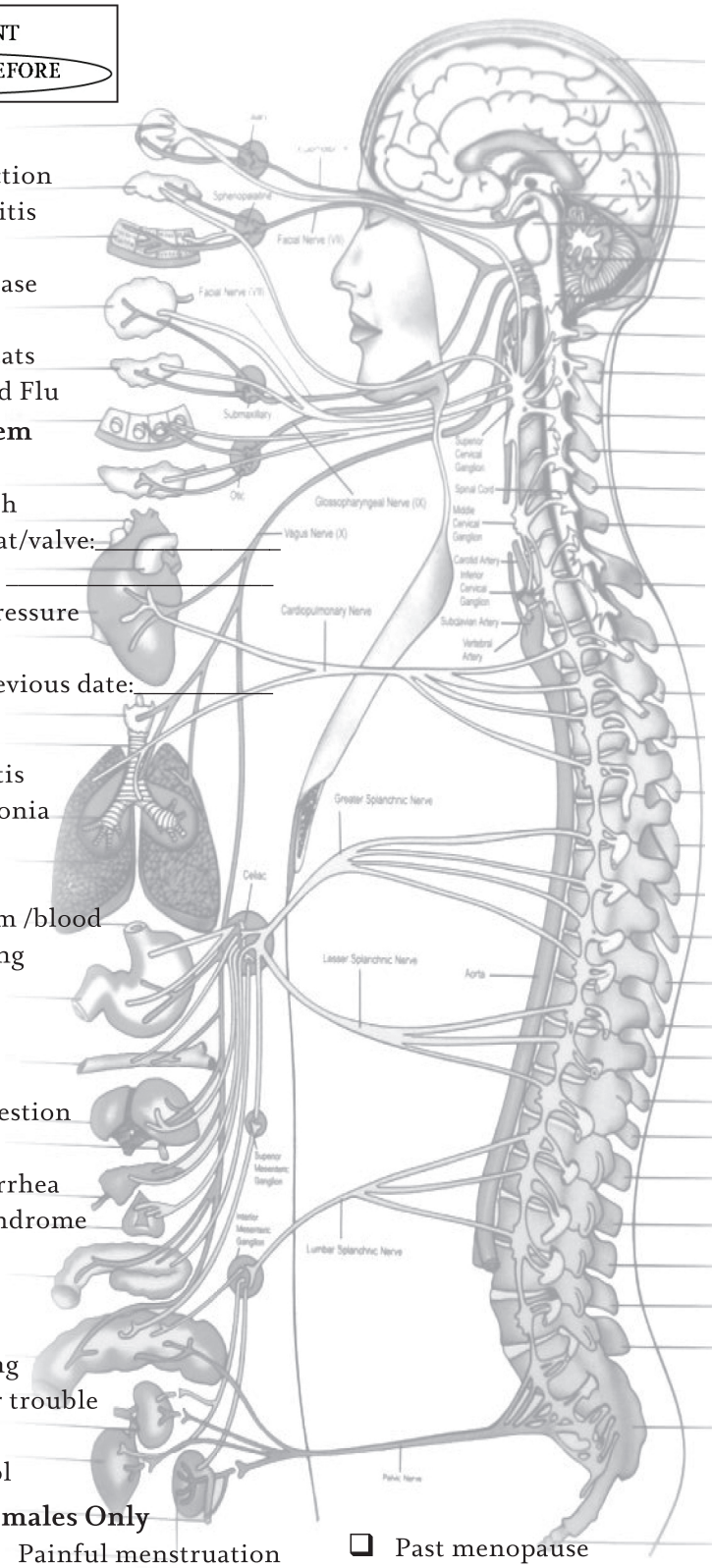
Health Concerns

Please check/circle any of the following signs of organ malfunction or dis-ease you have experienced

☑ CURRENT
EXPERIENCED BEFORE



Immune System
- ❑ Earaches/ear infection
- ❑ Sore throat/tonsilitis
- ❑ Sinus problems
- ❑ Autoimmune disease
- ❑ Antibiotic use
- ❑ Fever / chills / sweats
- ❑ Frequent colds and Flu

Cardiovascular System
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Irregular heart beat/valve: _____
- ❑ Heart medication: _____
- ❑ High/low blood pressure
- ❑ Swelling of legs
- ❑ Heart Attack – Previous date: _____

Respiratory System
- ❑ Frequent bronchitis
- ❑ History of pneumonia
- ❑ Asthma/allergies
- ❑ Chronic cough
- ❑ Spitting up phlegm /blood
- ❑ Difficulty breathing
- ❑ Tuberculosis
- ❑ Pneumonia

Digestive System
- ❑ Heartburn / indigestion
- ❑ Stomach cramps
- ❑ Constipation /diarrhea
- ❑ Irritable bowel syndrome
- ❑ Crohn's disease
- ❑ Ulcers
- ❑ Belching /gas
- ❑ Nausea or vomiting
- ❑ Liver /gall bladder trouble
- ❑ Colon trouble
- ❑ Black /bloody stool
- ❑ Diabetes

Females Only
- ❑ Painful menstruation
- ❑ Irregular cycle
- ❑ Excessive /irregular flow
- ❑ Excessive cramping/pain
- ❑ Abnormal discharge
- ❑ Hot flashes
- ❑ Past menopause
- ❑ Miscarriages #_____
- ❑ Breast pain/lumps
- ❑ Infertility
- ❑ Currently pregnant? Y or N
- ❑ Date of last menstrual period: _____

General Symptoms
- ❑ Dizziness
- ❑ Blurred /failing vision
- ❑ Deafness /ringing in ears
- ❑ Thyroid problems
- ❑ Fainting / dizziness
- ❑ Seizures / convulsions
- ❑ Skin problems
- ❑ Tremors
- ❑ Loss of balance
- ❑ Unexplained weight loss/gain
- ❑ Anemia
- ❑ Alcoholism
- ❑ HIV/AIDS
- ❑ Loss of sleep/difficulty sleeping
- ❑ Poor memory /concentration
- ❑ Learning disability
- ❑ Irritable /nervous /tension
- ❑ Anxiety/ depression
- ❑ Decreased energy / fatigue
- ❑ Tired /lethargic
- ❑ Cancer: _____
- ❑ Weight trouble
- ❑ Sexual dysfunction/Infertility

Musculoskeletal System
- ❑ Headaches: tension /migraine
- ❑ Neck pain /stiffness
- ❑ Tension across shoulders
- ❑ Pain between shoulders /stiffness
- ❑ Numbness /tingling: hands /arms
- ❑ Wrist/hand pain
- ❑ Scoliosis / spinal curvature
- ❑ Hip pain
- ❑ Iliotibial band syndrome
- ❑ Low back pain / stiffness
- ❑ Numbness/tingling in legs/feet
- ❑ Poor posture
- ❑ Painful tailbone
- ❑ Foot trouble, L R
- ❑ Knee pain
- ❑ Foot pain
- ❑ Shin splints
- ❑ Bladder problems
- ❑ Arthritis/swelling

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Terms of Acceptance

When a person seeks chiropractic health care and when a chiropractor accepts a person for such care, it is essential that both are speaking and working for the same goal. Chiropractic does NOT treat diseases or symptoms like medicine. Chiropractic has only one goal:

TO LOCATE, ANALYZE, AND CORRECT SPINAL INTERFERENCE TO THE NERVOUS SYSTEM

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The **SUBLUXATION** (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain, and promote health.

I will have an opportunity to discuss with the doctor and/or staff, the nature and purpose of chiropractic adjustments and other procedures, as well as any questions I have regarding the specific Chiropractic technique performed. I understand that the results expected are not guaranteed, as every person is unique.

I hereby request and consent to the performance of chiropractic procedures including diagnostic x-rays, if necessary, on me by the Doctor and/or anyone working in this clinic authorized by the Doctor.

I understand that to provide me with Chiropractic goods and services, Appleview Chiropractor Clinic will collect some personal information about me (e.g., home telephone number, health history). I agree to Appleview Chiropractor Clinic collecting and using personal information about me as it pertains to my health.

I further understand and am informed that, as in all health care, in the practice of manipulation by medical doctors, physiotherapists and chiropractors there are some very slight and minimal risks to care, including, but not limited to: minor muscle strains and sprains, rib fractures, disc injuries and cerebral vascular accidents (CVA). I do not expect the doctor to be able to anticipate and explain all risks and complications, and 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 interests.

I have read the above consent. I will have an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover todays exam and not withstanding, may exacerbate and irritate your present or current condition.

I understand that the purpose of today's visit is to determine if I am a candidate for chiropractic care and that I am responsible for any fees agreed upon between myself and the attending doctor. All examination fees will be explained to me before any tests are performed.

TO BE COMPLETED BY PATIENT:

_____ _____

SIGNATURE OF PATIENT *PRINT PATIENT'S NAME*
(OR PARENT/GUARDIAN)

_____ _____

DATE SIGNED WITNESS