IMPULSE CHIROPRACTIC

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Patients Information: Preferred Name:_____

Child's First Name: _____ Middle Initial: _____ Child's Last Name: _____

Address: _____ City: _____ Prov:_____ Postal Code: _____

Care Card Number: _____ Birthdate (m/d/yr) _____/_____/ _____ Age:_____

Mother's Name: _____ Father's Name: _____

Mother's Cell Number: _____ Father's cell Number:_____

Parents' Email: _____

Birth Weight: _____ Current Weight: _____ Height: _____ Number of Siblings: _____

Type of Birth: ☐ Normal Vaginal Birth ☐ Home Birth ☐ Forceps ☐ Hospital Birth ☐ Breech ☐ Caesarean ☐ Suction

Problems During Pregnancy, Labor and Delivery: _____

_____

_____

Reason For Visit: _____

_____

Health History:

Jaundice at Birth: Yes No Cyanosis at Birth: Yes No

Congenital Anomalies or Defects: _____

_____

Quality of Sleep: ☐ Good ☐ Fair ☐ Poor

Number of Hours of Sleep per Night: _____

Family Doctor / Pediatrician: _____

Obstetrician / Midwife: _____

Immunization History: _____

_____

Who can we thank for this referral?

☐ Patient from this office (name)

_____

☐ Other Health Care Professional (name)

_____

☐ Walk By
☐ Website
☐ Sign
☐ Google
☐ Other internet search engine
☐ Other (specify) _____

Childhood Disease:

☐ Chicken Pox ☐ Mumps ☐ Measles ☐ Rubella ☐ Rubeola ☐ Whooping Cough ☐ Other: _____

Symptoms and Ill Health:

Please circle either C for Current or P for Past diseases or conditions your child might have now or have had in the past.

C P - Dizziness
C P - Backache
C P - Chronic Earaches
C P - Diarrhea
C P - Anemia
C P - Headache(s)

C P - Poor Appetite
C P - Hyperactivity
C P - Colds / Flu
C P - Joint Problems
C P - Bed Wetting
C P - Asthma

C P - Allergies
C P - Behavioral Problems
C P - Fainting
C P - Sinus Trouble
C P - "Growing Pains"
C P - Neck Problems

C P - Leg Problems
C P - Constipation

Has your child undergone any medical care?_____

What medications is your child currently taking? _____

Surgeries? _____

History of Accidents or injuries: _____

_____

Fee Schedule:

Initial Consultation Fee: $125
Subsequent Visit Fee: $75
X-ray Fee: $37.50 per view
Nervous System Scan: $75
FOB or ID Card: $5.00 (Refundable with un-damaged devices)

I the undersigned, understand that the services rendered in this office are the responsibility of myself, should medical services plan or other third party plan fail to pay all or part of the amount due. I understand 24 hours notice is requested for cancellation of an appointment. I, the undersigned, also understand that each Practitioner is an independent and separate practice operating under Impulse Chiropractic and Massage Therapy Clinic. I hereby authorize the doctors in this clinic to examine my condition and render care as deemed necessary. In the event that X-rays are necessary in my case, I understand and agree that X-rays taken in this clinic are the property of Impulse Chiropractic Clinic, and will remain in this clinic where they can be reviewed for me by the Doctors. I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that fees for professional services are due when rendered. I understand that if I suspend or terminate my care, any fees for professional services will become immediately due and payable.

Childs name: _____

Parent or Guardian's Signature Authorizing Care: _____ **Date:** _____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Updated: September 2025

CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about 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. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____
Patient Name (print)

_____ _____ _____
Patient/Guardian Signature Date Chiropractor Signature