

## **IMPULSE CHIROPRACTIC**

Dr. Leong C. Wong Dr. Joe Janek Dr. Christopher Leong Dr. Will Mitchell Dr. Jin Ho Kim

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:	er's Cell Number: Father's cell Number:			
Parents' Email:				
Birth Weight: Current Weig	ht: Heigh	t: Number of Siblings:		
Type of Birth:   Normal Vaginal Birth	☐ Home Birth ☐ Force	eps □ Hospital Birth □ Breech □ Caesarean □ Suction		
Problems During Pregnancy, Labor and Delivery:				
Reason For Visit:				
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 Health History:		Who can we thank for this referral?		
Jaundice at Birth: Yes No Cyanosis a		□ Patient from this office (name)		
Congenital Anomalies or Defects:	<del></del>	☐ Other Health Care Professional (name)		
Quality of Sleep: Good D	Fair 🗆 Poor	——————————————————————————————————————		
Number of Hours of Sleep per Night:		□ Walk By		
Family Doctor / Pediatrician:		☐ Website☐ Sign		
Obstetrician / Midwife:		Google		
Immunization History:		☐ Other internet search engine		
		□ Other (specify)		

Chicken Pox   Mamps   Measles   Rubella   Rubeola   Thooping Cough   Other:	Childhood Disease:					
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 - Poor Appe C P - Allergies C P - Leg Problems C P - Belavioral Prob C P - Constipation C P - Chronic Ear- C P - Hyperactive lens achus ity C P - Bianting C P - Diarrheu C P - Joint Prob C P - Sinast Trouble C P - Anends C P - Joint Prob C P - Working Psins" C P - Headache(s) lems C P - Bed Worting C P - Work Problems C P - Mack Problems C P - Mack Problems C P - Anends C P - Joint Prob C P - Work Problems C P - Mack Problems C P - Bed Worting C P - Bed Worting C P - Neck Problems C P - Asthma  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 Pee: \$75  X-ray Fee: \$37.50 per view Nervous System Scan: \$475  Nervoy System Scan: \$475  Nervoy System Scan: \$475  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 concellution 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 examine any 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 Ingulse Chiropractic Clinic, and will remain in this clinic are the property of Ingulse Chiropractic Clinic, and will remain in this clinic are and the property of the cent that X-rays are necessary in my case, I understand and agree that X-rays taken in this clinic are the property of Ingulse Chiropractic continued that it is linic are the property of Ingulse Chiropractic continued that the services m	□ Chicken Pox □ Mumps □ Measles □ Rubella □ Rubeola □ Whooping Cough □ Other:					
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Parent or Guardian's Signature Authorizing Care: \_\_\_\_\_\_ Date: \_\_\_\_\_



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		