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

C P - Dizziness	C P - Poor Appetite	C P - Allergies	C P - Leg Problems
C P - Backache	C P - Hyperactivity	C P - Behavioral Problems	C P - Constipation
C P - Chronic Earaches	C P - Colds / Flu	C P - Fainting	
C P - Diarrhea	C P - Joint Problems	C P - Sinus Trouble	
C P - Anemia	C P - Bed Wetting	C P - "Growing Pains"	
C P - Headache(s)	C P - Asthma	C P - Neck Problems	

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 cancella-tion 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: _____

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 proceeding with 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 exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of neck, back, and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headaches, 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 a 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 disc**- 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 degenerated 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 the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs and 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 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 travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequent, and may be explained because an artery was already damaged and the patient was progressing toward 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 stroke.

The consequences of a stroke can be very 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 your care.
Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS 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