ALL SEASONS CHIROPRACTIC

Dr. Trevor Winzoski

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NEW PATIENT INFORMATION – Children's Intake Form

DATE:_____, 20____

CHILD'S NAME (first/last)_____ M/F (circle)

Birth Date (D/M/YYYY) _____ Current Age _____ Current Height:_____

Mailing Address:_____

City/Town: _____ Prov: _____ Postal Code: _____

Home Ph#_____

MHSC Registration # (9 DIGIT) _____ # (6 DIGIT) : _____

Mother's/Guardian's Name:_____

Address: (if different from above)_____

City/Town: _____ Prov: _____ Postal Code: _____

Home ph#_____ Wk#_____ Cell#_____

Father's/Guardian's Name:_____

Address: (if different from above)_____

City/Town: _____ Prov: _____ Postal Code: _____

Home ph#_____ Wk#_____ Cell#_____

OTHER CHILDREN (names/ages) _____

How did you Hear about our Office?_____

CHIROPRACTIC HISTORY:

Has your child ever been to a chiropractor before?: Y / N Date of last visit: _____

Name of last chiropractor:_____

MEDICAL HISTORY:

Is your child under current medical care? Y / N If, yes, why?_____

_____

What medications, if any, is your child currently taking?_____

_____

Is your child vaccinated? Y / N Which vaccines?_____

Please complete page 2

IF YOUR CHILD IS <u>5 YRS OR YOUNGER</u>: Please tell us about the following

Any illness during pregnancy?_____

Drugs/medication/tobacco/alcohol use during pregnancy?_____

Labor was chemically induced?_____

Pulling or twisting during delivery?_____

Forceps/Vacuum extraction?/C-section?_____

Premature delivery?_____

Treated for jaundice?_____

Experienced/experiencing colic?_____

Nursing problems?_____

<u>FOR ALL NEW PATIENTS:</u>

HAS YOUR CHILD EVER EXPERIENCED ANY OF THE FOLLOWING:*(please check all that apply)*

□ Headaches	□ Digestive Disorders	□ Behavioral Problems
□ Dizziness	□ Neck pain	□ Poor Appetite/eating problems
□ Ear infections	□ Fainting	□ Diarrhea
□ Stomach Aches	□ Seizures/Convulsions	□ Growing pains
□ Joint Problems	□ Constipation	□ Backaches
□ Allergies	□ Sinus Trouble	□ Asthma
□ Hyperactivity	□ Chronic Colds/Flu	□ Walking Trouble
□ Bed Wetting	□ Broken Bones	□ Sleeping Problems

Has your child ever sustained an injury playing sports? Y / N If yes, please explain_____

_____

Has your child ever been in an auto accident? Y / N If yes, please explain_____

_____

Has your child ever sustained any falls? Y /N If yes, please explain_____

_____

PURPOSE OF THIS VISIT:

_____ Wellness Checkup _____Injury or Accident _____Other

Please explain:_____

_____

CHILD'S CURRENT HEALTH ISSUES:

When did your child's current health issues first begin?_____

Is your child experiencing pain or discomfort? Y / N

If yes, please identify where and for how long_____

_____

Have you seen any other doctors for this problem? Y / N If yes, who?_____

How long ago? ___ days ____weeks ____ months ____ years

What were the results of past treatment?_____

Is your child's condition: ___rapidly improving ____improving slowly ____about the same ___ gradually worsening ____on and off?

I understand that I am directly and fully responsible to Dr. Winzoski for all fees associated with chiropractic care my child receives. I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____

Parent or Legal Guardian's Name (Print)

_____ _____

Parent or Legal Guardian's Signature Date

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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 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 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 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 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 infrequently, 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 including 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