# ALL SEASONS CHIROPRACTIC

***Services provided by Trevor Winzoski Chiropractic Corp.***
185a Stone Bridge Crossing, Steinbach, MB, R5G 2J2 Telephone 204-326-5800 Fax 204-346-1076

## NEW PATIENT INFORMATION – Children's Intake Form

DATE:_____, 20_____

**CHILD'S NAME (first/last)**_____ Gender_____

Birth Date (DD/MM/YYYY) _____ Current Age _____ Current Height:_____

Mailing Address:_____

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

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#_____

Email:_____

☐ ***Yes! Please send me*** ☐ ***text message alerts or*** ☐ ***emails for upcoming appointments/events***

**Father's/Guardian's Name:**_____

Address: (if different from above)_____

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

Home ph#_____ Wk#_____ Cell#_____

Email:_____

☐ ***Yes! Please send me*** ☐ ***text message alerts or*** ☐ ***emails for upcoming appointments/events***

OTHER CHILDREN (names/ages) _____

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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?_____

**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 ____recurring off and on

☐ 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 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 show n to be effective for complaints of the neck, back and other areas of the body caused by 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 or 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 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)

_____ _____
Parent/Guardian Signature Chiropractor Signature

Date:_____, 20____