

THRIVE

Chiropractic & Wellness Centre

Child's Name: _____ Sex: Male _____ Female _____
Birthdate: _____ Age: _____
Parents: _____ Number of children: _____
Address: _____ City: _____
Postal Code: _____ Phone (cell): _____ Phone (work): _____
Email: _____

Alberta Health Care #: _____

*Please be advised that personal health care numbers are collected in accordance with the Alberta Health Act. Numbers are protected and used solely for the purposes of diagnosis, treatment, and referral. Alberta Health Care currently does not make payments for any portion of treatment offered at Thrive Chiropractic & Wellness Centre.

Medical Doctor/Pediatrician: _____ Last visit to MD: _____
Emergency Contact Name: _____ Phone: _____

Who can we thank for referring you to our office? _____
If you were not referred by a friend or family, how did you hear about our office? _____
Has your child ever received Chiropractic care before? Yes No
If Yes, who _____ When was the last visit? _____

Life Events

PREGNANCY

How many weeks did you carry? _____
Did you require any medication or surgeries during pregnancy? Yes No
Did you have any complications through your pregnancy? Yes No

BIRTH

The birth of your child can give us vital clues to potential spinal problems. Please answer the following questions about the delivery and birth of your child.

Please check ✓ the following:

Did you use a midwife? ___ Obstetrician? ___ Home Birth? ___ Hospital? ___
Did you have a C-section? ___ Vaginal birth? ___
Were you induced? ___ Epidural? ___ Were forceps used? ___ Vacuum Extraction? ___
What was the baby's APGAR Score at 1 minute? ___/10 5 minutes? ___/10 OR not sure ___
Any initial respiratory delay? ___ Purple markings on face? ___ Mis-shaped skull? ___ Jaundice? ___

Any problems during labour and delivery? _____

Did you breastfeed? ____ How long? _____ Bottle feed? ____ Formula? ____
Number of hours your child sleeps at night? ____ hrs. Quality of sleep: good ____ fair ____ poor ____
Was your child vaccinated? ____ List any vaccine reactions: _____

List any current medications or supplements your child is taking: _____

List any previous medication(s), for what condition, and the number of times it was prescribed: _____

List any emergency/hospital visits: _____

Please circle any of the following conditions which your child has experienced:

- | | | | |
|----------------------------|---------------|-----------------------|----------------------|
| Developmental delay | Allergies | Earaches/Infections | Fall (ex. From crib) |
| Constipation/Diarrhea | Headache | Growing pains | Bedwetting |
| Loss of appetite | Seizures | Convulsions | Chronic colds |
| Visual disorders | Hyperactivity | Poor sleeping habits | Fever |
| Poor sleeping habits | Joint pains | Night terrors | Recurrent fevers |
| Constant fatigue | Scoliosis | Arm/leg pain | Neck pain |
| Back pain | Sinus Pain | Recurrent Tonsillitis | Asthma |
| Recurrent chest infections | Hip problems | Poor social skills | Digestive disorders |
| Car accident | Dizziness | Learning difficulties | Stomach pain |

Specific Concern History

Reason for today's visit: Wellness Check-up or Specific Concern

If your child has symptoms or a complaint, briefly describe the problem here. _____

How and when did this problem start? _____

The problem is: Constant ____ Comes & Goes ____ Radiates/Travels (where?) _____

If he/she is experiencing pain, is it: Sharp ____ Dull ____ Throbbing ____ Aching ____ Shooting ____

What aggravates the condition/pain? _____

What relieves the condition/pain? _____

Please describe any past or current treatment(s) and results: _____

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 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)

Signature of patient (or legal guardian)

Date: _____ 20____

Signature of Chiropractor

Date: _____ 20____

