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 (if you recall)

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

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BIRTH

Please check ✓ the following:

Did you use a midwife? ____ Obstetrician? ____ Home Birth? ____ Hospital? ____

Did you have a C-section? ____ Vaginal birth? ____

Were any interventions used? (circle all that apply)

Induction Epidural Forceps Vacuum Extraction

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: ___________________________________
____
What is your biggest concern about the issue at this time?_____________________________________

As a result of Chiropractic care, I would like my child to experience: (circle all that apply)

Improve Specific Concern Better Sport Performance Correct Posture Good Spinal Health

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)

_______________________________________ Date:_______________20____
Signature of patient (or legal guardian)

_______________________________________ Date:_______________20____
Signature of Chiropractor