PROGRESSIVE
CHIROPRACTIC

Child/Youth Health Questionnaire

205 – 2951 Tillicum Road, Victoria BC
250-590-7319 prochiro@shaw.ca

Personal Information

Today's Date: _____/______/______
M / D / Y

Name: ____ Age: ______ Birthday: (Day/Month/Year) ___/____/______

Home Address: ____City: _______________ Province: _______ Postal Code: __________

Email Address: _______________________________________ Cell Phone: ( ) ____________Home Phone: ( )_______________

Is your child/youth covered under any extended health insurance plans? Y / N

Insurance company: _________________________ PLAN/POLICY: ____________________ ID: _________________________

How was your child/youth referred to this office? Online ☐ walked-by ☐ community event ☐

Referred by a friend/family/co-worker ☐: Referral's first name: __________________ Last name:____________________

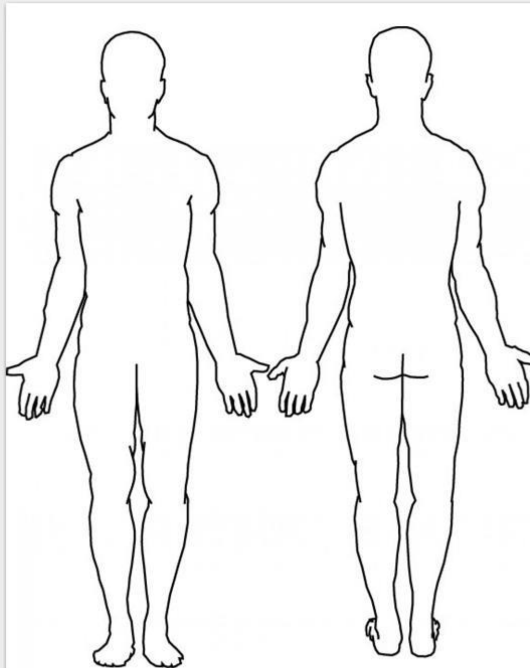
Would you like to receive email reminders ☐ **or** text message reminders ☐ the day before your child's next appointment?

(Cell phone **provider**- for text reminders _____________________)

Purpose of This Visit

What brings your child/youth to our office?____

____



Experience with Chiropractic

Has your child ever been to a Chiropractor before? ☐ YES ☐ NO When? ______________________________

Reason for visits: ______________________ How did they respond to care? ______________________

Health History and Conditions

Medication | Reason for taking

____

____

____

Please list any major surgeries, accidents, hospitalizations, or childhood illnesses:

____

____

____

PLEASE LIST ANY HEALTH CONDITIONS, CONCERNS, OR MEDICAL DIAGNOSES NOT MENTIONED:

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INFORMED 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 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. Patient 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 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 caused 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 child's condition and the treatment plan. I understand the nature of the treatment to be provided to my child. 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)

______________________________ Signature of Chiropractor

Date:______________________

Date:________________

CANCELLATION POLICY

Please note, we require a minimum of 24 hour's notice in the event of an appointment cancellation (exemption made for emergency situations). Should an appointment be missed or cancelled within 24 hours, a $30 cancellation fee will be applied and charged at your next appointment. Should an appointment be missed more than twice, a credit card will be required to be kept on file for future appointments.

By signing this, you agree to Progressive Chiropractic's cancellation policy.

_______________________________ _______________________________ _________________

Parent/Guardian Printed Name Signature Date

Direct Billing Consent, Authorization and Acknowledgement

(Only applicable to patients with insurance coverage)

Consent to Collect and Exchange Personal Information:

I authorize my health care provider, Progressive Chiropractic, to use and disclose personal information concerning any claims submitted on my behalf with the insurer/plan administrator and their service providers for the purposes of assessing my claims, investigations, and administering the group benefits plan.

I confirm I have consent from the primary insured plan member (if not myself) to collect, use and disclose any personal information about them for the same reasons as stated above.

I hereby authorize my health care provider to direct bill my insurance company on my behalf for services provided at Progressive Chiropractic. I acknowledge that if my claim is not paid in part or whole, or is not paid directly to the health care provider, that I will pay any balance owing immediately after treatment.

_______________________________ _______________________________ _________________

Parent/Guardian Printed Name Signature Date