Wellness for the Body
Massage Therapy & Healing Centre

Chiropractic Care - Pediatric

2418 Lakeshore Road West, Oakville, Ontario L6L 1H7
Phone: 905.465.4595 Web: www.wellnessforthebody.com

Patient and Guardian Information (please print clearly)

Name: _____ Date of Birth: mm/dd/yyyy ____/____/_____ Age: _____

Height/length: _____ Weight: _____ Gender: □ Female □ Male

Name of parents/guardians: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Please consider giving us a daytime phone number, in the event we need to reach you the same day as your appointment.

Phone: (H)_____ (M)_____ (B)_____

Email: _____ Would you like to receive our monthly e-newsletter? □ Yes □ No

Where did you find our number? _____

If online, what site referred you? □ Google □ Facebook □ Instagram □ Twitter □ Other: _____

Current Health Condition

Current health complaint(s): _____

When did this begin? _____ Has the condition been getting: □ Worse □ Better □ Stays the same

Frequency of pain: □ Constant □ Intermittent If intermittent, how often? _____

How long does each episode last? _____ When was the last episode? _____

What aggravates the condition? _____

What makes the condition feel better? _____

Were there any previous injuries to the area of complaint? □ No □ Yes When? _____

Has the child seen another health professional for this condition? □ No □ Yes Who? _____

Health History

Has the child seen a Chiropractor before? □ No □ Yes If yes, when was their last treatment? _____

Previous Chiropractor: _____ Phone: _____

List other current therapies (i.e. physiotherapy): _____

Medical Doctor: _____ Phone: _____ Last physical: _____

Current supplements/medications (conditions they treat): _____

_____

Previous fractures, surgeries, or hospitalizations (Please list and date): _____

_____

Please list the presence and location of any internal pins, wires, artificial joints or special equipment: _____

_____

please turn over...

History of Birth:

□ Hospital □ Medical □ Assisted Delivery
□ Birthing Center □ Midwife If yes: □ Forceps □ Induced Labour
□ Home □ Normal Delivery □ C-section □ Vacuum Extraction

Duration of gestation: _____ weeks Duration of birth: _____ hours

Medications delivered to mother during labour: _____

Birth weight: _____ Birth length: _____ APGAR: _____ (birth) _____ (5 min)

Describe any complications at birth: _____

Growth and Development:

At what age did the child:
Respond to sound _____ Hold up head _____ Teethe _____ Crawl _____

Follow an object _____ Vocalize _____ Sit alone _____ Walk _____

Chemical Stressors:

Any pets or smokers in the home? ..... □ No □ Yes
Was child breast fed? ..... □ No □ Yes If yes, for how long? _____
Did mom smoke while pregnant? ..... □ No □ Yes
Did mom drink while pregnant? ..... □ No □ Yes

Any illnesses mom had while pregnant: _____

Any meds/supplements mom took during pregnancy: _____

Any invasive procedures during pregnancy (e.g. amnio, U/S): _____

Child's food/juice intolerances (if any): _____

Are child's immunizations up to date? □ No □ Yes

Any negative reactions to immunizations that occurred: _____

Child's past medications (including antibiotics) and for what reason: _____

_____

Psychosocial Stressors:

Any difficulties with lactation? ..... □ No □ Yes
Any difficulties with bonding? ..... □ No □ Yes
Any night terrors, sleep walking, difficulty sleeping? ..... □ No □ Yes

Age of child entering daycare _____ Average hours of television per week _____ Average hours at play per week _____

Does child seem normal for age? □ Yes □ No If no, describe: _____

Traumatic Stressors:

Any traumas during pregnancy (e.g. falls, accidents): _____

Any evidence of birth trauma (e.g. bruises, odd shaped head, stuck in canal, long/short birth, cord around neck, respiratory depression): _____

_____

Any falls from couches, beds, etc.: _____

Does child carry a school backpack? □ No □ Yes Average weight of backpack: _____

Describe any behavioral problems and age of onset: _____

Describe any additional concerns: _____

Cancellation & Fee Policy

For a full detailed price list: www.wellnessforthebody.com

We require 24 hours' notice if you are unable to make your scheduled appointment. After an initial warning, there is a charge of $45.00 for a second missed appointment. All subsequent missed appointments will then be billed at the full regular fee.

Payment is due at the time services are rendered. This policy applies to all our patients. Patients with extended health care coverage should note, our office does not file claims on your behalf, nor bill your insurance company directly.

I understand and am aware of the Cancellation & Fee Policy. I also agree that if I am late for my appointment, I will receive the remainder of the appointment time and will be responsible for the full payment of the scheduled appointment.

_____	_____	_____
Patient Name (Please Print)	Signature of Patient (or Legal Guardian)	Date

Privacy Policy

Privacy of personal information is important to Wellness for the Body. We are committed to the collection, use and disclosure of this information in a responsible way. We will also try to be an open and transparent as to how we handle personal information.

Personal Information

Personal information is information about an identifiable individual. Generally, the information we collect is limited to your name, home contact information, gender, and age. As part of your patient file we retain your health history; health measurements and examination results; health conditions, assessment results and diagnoses; health services provided to you or received by you; your prognosis and other opinions formed; compliance with treatment; and the reasons for your discharge and discharge recommendations. We also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent; the use, retention and privacy protection protocols. Privacy protocols comply with the privacy legislation, standards of our regulatory body, the College of Chiropractors of Ontario and the law.

Staff Members

Staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information. These individuals include the clinic records personnel that control access to your patient file, therapists, clinic administration, and, when necessary, authorized individuals who may inspect our records as part of the regulatory activities in the public interest.

Disclosure of Personal Information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we outline below how our clinics use and disclose this information:

- To deliver safe and effective patient care
- To enable us to contact you
- To communicate with other health care providers
- For teaching and demonstrating on an anonymous basis
- To complete and submit claims on your behalf to third party payers
- To comply with legal and regulatory requirements under the Chiropractic Act and the Regulated Health Professions Act
- To process payments and collect unpaid accounts
- For research purposes

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use, and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

I have reviewed the above information that explains how our clinic will use my personal information. I agree that Wellness for the Body can collect, use, and disclose my personal information as set out above in the College's privacy code.

_____	_____	_____
Patient Name (Please Print)	Signature of Patient (or Legal Guardian)	Date

please turn over...

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.

_____	_____	_____
Patient Name (Please Print)	Signature of Patient (or Legal Guardian)	Date
_____	_____	_____
Name of Chiropractor	Signature of Chiropractor	Date