

Patient Name:

Inside-Out Chiropractic Center New Patient Form – Child

Demographic Information

Child's Name: _____
Address: _____
City: _____ Province/State: _____
Postal/Zip Code: _____
Date of Birth (mm/dd/yy): ____/____/____ Age: _____ Gender: M or F

Parent's Name: _____
I consent to receiving calls and/or having a message left at:
Home Cell Work (please circle ALL that apply)
Home Phone Number: () _____
Cell Phone Number: () _____
Work Phone Number: () _____
Would you like to receive appointment reminders via email? Y or N
Email address: _____
Is it okay to send you a newsletter or office announcement via email? Y or N

Child's Provincial Health Care Number: _____

Who may we thank for referring you to this office? _____
Has your child been adjusted by a chiropractor before? Y or N
Chiropractor's Name: _____
Reason for visit: _____
When was your child's last visit at a chiropractor's office? _____
Approximately how many visits has your child had since July 1? _____

Patient Name:

My child was delivered at: Home or Hospital or Other: _____
The labor was: easy moderate hard
The length of time spent in delivery and labor was: _____
The use of the following was required (*please circle all applicable*): Forceps Vacuum C-Section

Has your child ever:	If yes, please explain
...taken antibiotics? Y or N	_____
...been vaccinated? Y or N	_____
...had a severe fall? Y or N	_____
...been in a car accident? Y or N	_____
Is your child:	
... accident prone? Y or N	_____
...currently taking any medication (s)? Y or N	_____
... having difficulty interacting with others? Y or N	_____

Please check each of the following conditions that your child current has or has had in the past.

- | | |
|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Attention problems | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Rocking behavior |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Shaking |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sleeping disorders |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Tubes in the ears |
| <input type="checkbox"/> Ear problems | <input type="checkbox"/> Twitching |
| <input type="checkbox"/> Fatigue/Lethargy | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Other: _____ |

Review of Systems/Family Health History
(please fill out attached form)

Patient Name: _____

FAMILY HEALTH HISTORY

Please check off all conditions that apply to you (Patient) and any family members and indicate to whom (i.e.; child, spouse, mother, etc...). In the notes column indicate any other pertinent information (i.e.; Right side, how long, etc...).

Condition:	Patient	Family	Notes/Comments:
Allergies			
Arm/hand pain			
Arthritis			
Asthma/difficulty breathing			
ADD/ADHD			
Back pain			
Bed Wetting			
Behavior/Learning Disorders			
Bladder /Urinary Issues			
Blood Pressure High/Low			
Carpal Tunnel Syndrome			
Chest pain			
Constipation/ Irritable Bowel/ Colitis			
Decreased energy/ Fatigue			
Depression			
Diabetes			
Difficulty concentrating			
Digestion issues			
Disc Problems			
Dizziness/ Vertigo			
Epilepsy			
Fertility Issues			
Fibromyalgia			
Foot pain			
Frequent Colds			
Frequent Ear infections			
Headaches/migraines			
Hearing Loss			
Heart burn/Acid reflux			
Hip			
Hyperactivity			
Imbalance / Clumsiness			
Leg pain			
Memory Loss			
Menstrual Difficulties			

Patient Name: _____

Neck pain/ Stiffness			
Pinched nerves			
Poor Posture			
Ringling in ears/ tinnitus			
Sciatica			
Scoliosis			
Shoulder Issues			
Sinus Problems			
Skin issues			
Sleep issues/Apnea			
Stomach Ulcers			
Stress/ Anxiety			
Tingling/ Numbness			
TMJ / Jaw pain			
Tremors			
Vision Loss			
Whiplash			
Other concerns:			



CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment **FORM L**

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

Patient Signature (Legal Guardian)

Witness of Signature

Name: _____
(please print)

Name: _____
(please print)