PEDIATRIC NEW PATIENT INFORMATION

Dear Parent

Please complete this questionnaire. Your answers will determine if Chiropractic can help your child. Please answer ALL questions, even if they seem unrelated to your child. There are conditions Chiropractic can help of which you may be unaware. If we do not sincerely believe the condition will respond satisfactorily, we will not accept the case.

PERSONAL HISTORY

Name _____ Date _____

Alberta Health Care No. _____ _____ Phone No. _____

Address _____ Postal Code _____

Age _____ Weight _____ Height _____ Parents _____

Birthdate _____ Birthplace _____

School _____ Family Doctor _____

Referred to this office by _____

CURRENT HEALTH CONDITION

Present complaint _____

Previous treatment for this condition _____

When did this condition begin? _____

What do you believe caused this condition? _____

Are there others in your family with this same condition? _____

Presently taking medication? (please list) _____

PAST HEALTH HISTORY

Surgery/Operations: ___ Appendix ___ Tonsils ___ Hernia ___ Tubes in ears

Other _____

For newborns; birth process ___ Normal ___ Easy ___Hard ___ Abnormal

Major injuries or falls, fractures (etc...) _____

_____

Previous Chiropractic care (approximate date / name of Dr.) _____

Treatment for any health conditions in last year ___ Yes ___ No

If yes, please explain _____

Any reactions to vaccinations / medications ___ Yes ___ No

_____

Please check any of the following conditions that are a problem, and □X□ any that were a problem in the past.

Muscle & Joint

__ sore muscles
__ sore joints
__ growing pains
__ muscle cramps
__ back problems
__ neck problems
__ painful tailbone
__ pain between shoulders
__ spinal curvature
__ arthritis
__ difficulty chewing/clicking jaw
__ general stiffness
__ walking problems
__ feet turn in/out
__ coordination problems
__ headaches

ORGANIC

__ bedwetting
__ constipation/diarrhea
__ anemia
__ thyroid
__ vomiting
__ skin eruptions/eczema

General

__ fatigue
__ allergies
__ difficulty sleeping
__ dizziness
__ fainting
__ ear aches
__ nosebleeds
__ sore throat
__ asthma
__ chronic cough
__ enlarged glands
__ loss of weight
__ poor/excessive appetite
__ junk food
__ nervousness
__ depression/confusion
__ visual problems
__ dental problems
__ hearing problems
__ hyperactivity
__ behavioral problems
__ frequent colds/flu
__ epilepsy
__ rheumatic fever
__ stomach aches

I am authorized to, and do give authorization for this child to be treated.

Signature _____ Date _____

Chiropractic Wellness Centre
Dr. Imran Dharshi
Box 1103 133 3rd Ave W.
Drumheller, AB
T0J 0Y0

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 rather, recent studies indicate 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)