

Ajax Chiropractic & Wellness
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Pediatric Chiropractic New Patient Form

Patient and Guardian Information (please print clearly)

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

Height/length: _____ Weight: _____ Family Doctor: (name) _____ (number) _____

Name of parents/guardians: _____

Primary Address: _____ City: _____ Postal Code: _____

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

Email address: _____

How did you find out about us? _____ If online, what site referred you? _____

Emergency Contact: (Name) _____ (Relationship) _____ (Phone number) _____

What is your reason for bringing your child into our office today? _____

What goals would you like to achieve for your child's health? _____

Rate your level of commitment to helping your child achieve these health goals:
____ Low ____ Medium ____ High ____ Very High

Previous chiropractic care? _____ Dr.'s name/last visit _____

Describe the care your child received _____

If your child is not experiencing symptoms and you simply request wellness services please check here __ and skip to the next section. If there is a specific health concern please answer the following questions:

Describe the nature of your child's symptoms or health concern:

1. _____
2. _____
3. _____

When did this problem start? _____ How did it start? _____

Psychosocial Stressors	Traumatic Stressors	
Any difficulties with location? ___ _____	Any traumas during pregnancy? (e.g. falls, accidents) _____ _____	<i>Describe any behavioural problems and age of onset:</i>
Any difficulties with bonding? ___ _____	Any evidence of birth trauma/ (e.g. bruises, odd shaped head, stuck in canal, long/short birth, cord around neck, respiratory depression) _____ _____	
Any night terrors, sleep walking, difficulty sleeping? _____ _____	_____	<i>Describe any additional concerns:</i>
Age of child entering daycare? ___ _____	_____	
Average number of hours of television per week _____	Any falls from couches, beds, etc? _____ _____	
Does child seem normal for age? _____ _____	Weight of school backpack? ___ _____	
_____	Approximate hours per week spent at play? _____	

Please indicate if your child has experienced any of the following conditions currently (C) or in the past (P).

Measles	C or P	Seizures	C or P
Chicken Pox	C or P	Scarlet Fever	C or P
Mononucleosis	C or P	Colic/Gas/Cramping	C or P
Mumps	C or P	Diarrhea	C or P
Ear Infections	C or P	Digestive difficulties	C or P
Pneumonia	C or P	Constipation	C or P
Headaches	C or P	Frequent colds	C or P
ADD/ADHD	C or P	Coughing/Wheezing	C or P
Rubella	C or P	Sinus problems	C or P
Asthma	C or P	Cold sores	C or P
Hives/Rashes/Eczema	C or P	Strep throat/Tonsillitis	C or P
Allergies	C or P	Chronic runny nose	C or P
Hay fever	C or P	Anxiety	C or P
Temper tantrums	C or P	Bed wetting	C or P

Informed Consent to Chiropractic Adjustments and Care

Chiropractors locate, analyze and correct *subluxations* (spinal misalignments which cause nerve interference). Chiropractic improves the nerve supply to your entire body and allows the *innate healing power of your body* to work at maximum efficiency to restore, maintain and promote health.

Chiropractic care is considered to be one of the safest and most effective forms of health care. As in all health care, however, there are some slight and minimal risks to chiropractic care, including but not limited to, minor muscle strains and sprains, disc injuries and strokes. Tests will be performed on you to minimize this risk and the appropriate chiropractic adjusting techniques will be applied.

The doctor and/or staff will always be available to answer questions and discuss the nature and purpose of chiropractic procedures. Results cannot be guaranteed, as every person is unique.

Informed Consent to Chiropractic Adjustments and Care

"I have read the above and wish to rely on the doctor to exercise judgement during the course of my care which the doctor feels at the time, based on the facts then known, is in my best interest. I intend this consent to cover the entire course of treatment, including any x-rays that may be required, for my present condition and for any future condition(s) for which I seek treatment."

Patient's Name

Parent or Guardian Signature

Date

Disclosure of Personal Health Information

Please know that we are very concerned with protecting the privacy of your personal health information. While the law requires us to notify you about this disclosure, please understand that we have, and always will, respect the privacy of your health information. However, please be advised that it may be necessary for us to disclose your health information to another health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. I have read the above privacy pledge and agree to its terms.

Patient or Guardian Signature _____ Date _____