HOLISTIC INSTITUTE OF
Health & Fertility

**SOUTH** 143, 14919 Deer Ridge Dr. SE, Calgary T2J 7C4
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# CHIROPRACTIC PEDIATRIC INTAKE FORM

## Pediatric (age 0-12)

### Patient Information

Date: _____ Child's Name: (last) _____ (first) _____

Parent 1 Name: _____ Parent 2 Name: _____

Address: _____Postal Code_____

Phone: (1) _____ (2) _____ Email _____

Child's Age: _____ Weight: _____ Height: _____

Birth date: _____ Birth Place: _____

School/daycare: _____ Family MD/Pediatrician: _____

Referred by: _____

### Current Health Condition

Purpose of appointment/current complaint:

_____

When/how did the current complaint occur: _____

Is this complaint: (circle): new/recurring

Did it come on (circle): suddenly/gradually/comes & goes

Did a fall, injury or trauma contribute to the current complaint: _____

Is your child presently taking medication/or under any other medical care: _____

For what conditions: _____

### Past Health History

**Birth History:**

Length of Pregnancy: full term (weeks)_____ / early (weeks): _____/late (weeks): _____

Any issues during pregnancy for mom/baby: (position of baby, blood pressure etc.) _____

_____

Type of delivery: (circle) Normal vaginal/ Breech/ Cesarean Invasive procedures: Epidural/ Forceps/ Vacuum

Length of labour: _____ Normal/difficult

Birth Weight: _____ Birth Length: _____ Congenital anomalies: _____

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## Infant History:

Feeding: (circle) Breast/ Bottle/ Formula Latching well: Y/N Breast preference: Y/N/right/left

Sleep Quality: good/fair/poor Average hours/night _____ Average hours in a row: _____

Trouble falling asleep: (circle) always/occasional/never

## General Health History:

Any known Health conditions/Allergies:_____

Illness/Injuries: _____

Hospitalizations/Surgeries/ Stitches/ X-rays_____

Previous Massage/ Craniosacral Treatment: _____

Date: _____

Vaccination history: _____

Last doctor's appointment: _____Concerns: _____

Treatment for any health conditions in the past year: _____

## Lifestyle: please circle any that apply to your child

Activities: Basketball/ Dance/ Running/ Gymnastics/ Skiing/ Swimming/ Hockey/ Soccer /

Other: _____

Computer/desk time: _____hours/day

Diet: (circle) Good/fair/poor

Sleep Quality: (circle) Good/fair/poor

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Please **check** any of the following conditions that are **currently** a problem; and underline any that were a problem in the past:

**MUSCLE & JOINT**
sore muscles
sore joints
growing pains
muscle cramps
muscle jerking
back problems
neck problems
painful tailbone
pain between shoulders
spinal curvature
arthritis
difficulty chewing
clicking in jaw
general stiffness
walking problems
feet turn in/out
coordination problems
headaches
pain in ankles/knees/hips

**GENERAL**
fatigue
allergies
difficulty sleeping
dizziness/fainting
earaches/infections
nose bleeds
sore throat/ frequent colds/flu
asthma
chronic cough
enlarged glands
loss of weight
poor exercise/appetite
nervousness
depression/confusion
Vision/dental/hearing problems
hyperactivity
behavioral problems
Epilepsy/seizures
rheumatic fever
stomach aches

**INFANCY**
Colic
tilting head to one side
difficulty nursing
preferred side nursing
slow weight gain
fussing in specific positions
Screaming/crying

**ORGANS**
bedwetting
constipation/diarrhea
anemia
Thyroid issues
vomiting
skin eruptions/eczema

**OTHER CONCERNS**

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## HIHF CLINIC CANCELLATION POLICY

We understand at the Holistic Institute of Health and Fertility (HIHF) that unplanned events can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled with at least 24 hours notice.

We want to be available for your needs and the needs of all our clients. When a client does not show up for a scheduled appointment, another client loses an opportunity to be seen. In the event of a missed appointment or an appointment cancelled within less than 24 hours' notice, you will be charged the **FULL FEE.**

MasterCard, Visa and American Express are accepted at the clinic. Your credit card number will be kept on file to book/hold your appointment. Your credit card will only be charged should an appointment be missed without notifying the HIHF clinic.

Please indicate your acceptance of this policy by signing below. You are a valued patient, thank you for your understanding and cooperation.

Signature: _____ Printed Name: _____

Date: _____

*Signature of Parent or Guardian if the Patient is under 18 years of age:* _____

## HIHF CLINIC WAIVER

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by the Holistic Institute of Health and Fertility (HIHF) is based on traditional Chinese medicine, and/or therapeutic massage, and/or yoga principles only and does not constitute a Western Medical diagnosis. I understand that I am not to rely on these therapeutic diagnosis and treatments as my sole remedy for the treatment I am seeking.

I understand there may be some minor risks associated with these therapies including but not limited to slight bleeding, bruising, and mild dizziness. I understand clinic staff may review my records but all information will be kept confidential and will not be released without my written consent.

If no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a Western Medical doctor. Further, if I am concurrently undergoing Western Medical treatments, it is my responsibility to advise my physician of any of these therapies and/or herbal supplements I am concurrently taking.

I assume all risks and responsibilities for myself and release HIHF clinic and its agents from any injury or liability that may occur during a treatment session.

**Please sign and date below to indicate that you have read and understood this form.**

Signature: _____ Printed Name: _____

Date: _____

*Signature of Parent or Guardian if the Patient is under 18 years of age:* _____

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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

**CONSENT TO CHIROPRACTIC TREATMENT – FORM L**

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

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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.

_____ Date: _____ 20____.

Name (Please Print)

_____ Date: _____ 20____.

Signature of patient (or legal guardian)

_____ Date: _____20____

Signature of Chiropractor