

CONFIDENTIAL PERSONAL INFORMATION FOR INFANT / CHILDREN

Name _____ Alberta Health Care # _____ Age _____ Sex: M F

Address: _____ City: _____ Postal Code: _____

E-Mail address: _____ Height: _____ Weight: _____ Right or Left Handed

Birth date: _____ Parent(s)' name(s): _____

Home Phone: _____ Mother's work phone: _____ Father's work phone: _____

What is your reason for coming to our office? wellness maintenance specific symptom parent

If you came in with specific symptoms, what is your major complaint? _____

Who referred you to our office? _____ or phonebook location other _____

Previous chiropractor: _____ Date of last visit: _____

Type of Birth: Normal vaginal Suction Forceps Breech Cesarean

Location of birth: Birthing centre Home Hospital Other: _____

Birthing assistant: Midwife Spouse Medical Doctor Other: _____

During pregnancy, did the mother: Smoke Drink Drugs / medication: _____

Supplements / vitamins: _____

Were there any problems or complications during pregnancy? _____

Was child born: Early (premature) Late APGAR score (if known): _____

Birth weight: _____ lbs. _____ ounces Birth length: _____

Any evidence of birth trauma? (check **all** that apply): Bruising Odd Shaped Head Stuck in birth canal

Cord around neck Fast birth Excessively long birth Respiratory depression Other: _____

Was your child subjected to any of the following? (check **all** that apply): Vitamin K shot Separation from mother

Silver nitrate drops in eyes Hepatitis shot Incubation Other: _____

Was infant alert & responsive within 12 hours of delivery? Yes No, explain: _____

Any congenital abnormalities / defects present? _____

Vaccination history: _____

Reason for vaccination(s): Informed choice Unaware that vaccines are optional Other: _____

Any reactions to vaccine(s)? _____

Infant feeding: Breast Bottle Formula Goat's milk Other: _____

Hours of sleep per night: _____ Quality of sleep: Good Fair Poor

Has your child had any falls from: Couches Beds Change tables Other: _____

Any traumas resulting in fractures or stitches? Yes No If yes, please list: _____

Any hospitalizations or surgeries? Yes No If yes, please list: _____

Any medication or antibiotics taken? Yes No If yes, please list: _____

Do you feel that your child's social & emotional development is normal for their age? Yes No

If no, please explain: _____

Has this child suffered from: (check all that apply)

- Dizziness Diabetes Bleeding nose Jaundice
- Anemia Poor Appetite Bed Wetting Fainting
- Backaches Neck Problems Joint Problems Tuberculosis
- Headaches Digestive Disorders Rheumatic Fever Hyperactivity (A.D.H.D.)
- Convulsions Walking Problems Arm Problems Blood Disorders
- Heart Trouble Hypertension Asthma Sinus Trouble
- Orthopedic Problems Sugar Concentration Paralysis Broken Bones
- Leg Problems Stomach Aches Chronic Earaches Colds / Flu
- Allergies Constipation Diarrhea A.D.D.
- Behavioral Problems Muscle Jerking Ruptures / Hernias "Growing Pains"
- Other _____

Parent's signature : _____ Date : _____

Fish Creek Chiropractic

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Informed Consent to Chiropractic Treatment

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)