Dr. Mark Guker
Dr. Phil Sammut
1-2445 Eagle St N
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ReAlign Health Child Intake Form

Please complete the following as completely as possible. If you need assistance, please ask the front desk staff and they will be glad to assist you.

Child's Name_______________________________________ Date______________
Parent(s) Name____
Siblings Names(Ages)____
Address_____________________________________ City___________ Prov. ____
Postal Code__________ Home Phone(____)_________ Bus Phone(____)_________
Date of Birth_____________________ Age______ Referred by _________________

Has your child ever received chiropractic care? ***Yes No***
If yes, previous DC's name and last visit date?_______________________________
Name of Medical Doctor ____
Date of last MD visit and reason ____

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)
PARENT(S) NAMES ________________________________ WORK TEL ___________
I hereby authorize and consent to the chiropractic evaluation of my child.
PARENT/GUARDIAN SIGNATURE_________________________DATE__________
WITNESS SIGNATURE____

PRESENT HEALTH COMPLAINTS/CONCERNS:

Major____

Minor____

When did this problem

begin?____

Is this problem (circle)***occasional frequent constant intermittent***

Does problem radiate? ***Yes No*** If Yes, where?

____

What makes this worse?____

What makes this better?____

Is the problem worse during a certain time of the day? ***Yes No***
If Yes, when?____

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Childs Name: ____________________

Does this interfere with the child's sleep?____ eating?____ daily routine?___

Is this becoming worse?

____

Other professionals seen for this condition?

____

Results with that treatment?

____

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS: (please tick if your child has had any of the following)

__ headaches
__ dizziness
__ fainting
__ fatigue
__ irritability
__ depression
__ loss of balance
__ loss of concentration
__ loss of memory
__ ears buzzing
__ poor coordination
__ vision changes
__ loss of smell
__ loss of taste
__ light sensitivity
__ face flushed
__ cold sweats
__ bronchitis
__ pneumonia
__ difficulty breathing
__ shortness of breath
__ asthma
__ urinary problems
__ constipation
__ diarrhea
__ weight loss
__ weight gain
__ dental problems
__ fevers
__ heart palpitations
__ chest pressure
__ breast pain
__ frequent colds
__ sinus congestion
__ sore throats
__ ear pain/infections
__ allergies
__ heartburn
__ bloating/gas
__ upper back pain
__ neck pain
__ low back pain
__ radiating pain
__ stiffness
__ reduced mobility
__ numbness in leg(s)
__ numbness in feet
__ numbness in hand(s)
__ weakness
__ muscle cramps
__ sleeping problems
__ other: ____

HISTORY OF BIRTH

What was the child's gestational age at birth? ____ weeks.

Birth weight _____lbs _____oz Birth length _____ inches

Was your child's birth at home, in a birthing center or in a hospital? (circle one)

Was the birth considered medical or midwife? (circle one)

What was the duration of the labour and birth? _____ hours

Was child born cephalic (head first) or breech (feet first)? (circle one)

Were there any complications? ***Yes No*** If Yes, please explain

____
____

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Childs Name: ___________________

Please circle any assitance which was used during the birth

Forceps ***Vacuum extraction*** ***C-section*** ***Episiotomy***

Was labour spontaneous or induced? (circle one)

Were medications or epidurals given to the mother during birth? ***Yes*** ***No***
If yes, what was given

____

APGAR score: at Birth ___/10 After 5 minutes___/10

GROWTH & DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? Yes No
If no, please explain

____

At what age did the child: Respond to sound _____ Follow an object _____
Hold up head _____ Vocalize _____
Sit alone _____ Teethe _____
Crawl _____ Walk _____

Do you consider the child's sleeping pattern normal? Yes No
If no, please explain

____

FAMILY HEALTH HISTORY

Please note any health problems (ie. cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:
Mothers family ____

Fathers family ____

Siblings ____

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

ReAlign
NATURAL HEALTH CLINIC

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Childs Name: ____________________

PHYSICAL STRESSORS

Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) ***Yes No***
Please explain ____

Any evidence of birth trauma to the infant? (please tick)

__bruising ***__odd shaped head***
__stuck in birth canal ***__fast or excessively long birth***
__respiratory depression ***__cord around neck***

Any falls from couches, beds, change tables, etc? ***Yes No***
If yes, please explain ____

Any traumas resulting in bruises, cuts, stitches or fractures? ***Yes No***
If yes, please explain ____

Any hospitalizations or surgeries? ***Yes No***
If yes, please explain ____
Any sports played? ____

Is a school backpack used? ***Yes No*** Is it heavy or light? (circle one)

CHEMICAL STRESSORS

Was this child breast-fed? ***Yes No*** If yes, how long? ______________________________

Formula introduced at what age? _________ Which formula? ________________________

Introduction of cow's milk at what age? ___________

Began solid foods at what age? __________ Type of foods? _________________________

Food/Juice intolerance? ***Yes No*** Type? _______________________________________

==

During pregnancy, did the mother smoke? ***Yes No*** How much? _______

drink? ***Yes No*** How much? _______

Any illnesses during the pregnancy? ***Yes No*** ______________________________

Any supplements taken during pregnancy? ***Yes No*** _______________________

Any drugs taken during pregnancy? ***Yes No***

____

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Childs Name: ____________________

Any ultrasounds? ***Yes*** ***No*** How many and reasons for being done?
____
____

Any invasive procedures during pregnancy (ie amniocentesis, CVS, etc.)? ***Yes*** ***No***
Please explain

____

Any pets at home? ***Yes*** ***No***

____

Any smokers in the home? ***Yes*** ***No***

Vaccination history Vaccinations and age given?
____
____

Any negative reactions? ***Yes*** ***No***
____

Any antibiotics given? ***Yes*** ***No*** Reason

____

PSYCHOSOCIAL STRESSORS

Any difficulties with lactation? ***Yes*** ***No***___________________________________

Any problems with bonding? ***Yes*** ***No*** __________________________________

Any behavioural problems? ***Yes*** ***No*** ____________________________

Any night terrors, sleep walking, difficulty sleeping? ***Yes*** ***No*** ________________

Age of child when began daycare? _________

Average number of hours of television per week? _____________

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

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below.

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

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