



Dr. Mark Guker
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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 _____

<u>AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)</u>	
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)

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



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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.

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.

Name (Please Print)

Date: _____ 20____.

Signature of patient (or legal guardian)

Date: _____ 20____.

Signature of Chiropractor

Date: _____ 20____.