REALIGN
LIVING HEALTHY

INFANT AND CHILDREN CHIROPRACTIC INTAKE (0-13 years)

Date: _____

Name (first and last): _____ Gender: ☐ FEMALE ☐ MALE

Child's Birthdate: _____ Age: _____

Parent(s)/Guardian(s) Name: _____

Address: _____

City/Province: _____ Postal Code: _____

Phone Number – Home: (____) _____ Mobile Phone: (____) _____

Email: _____

Whom may we thank for referring you to ReAlign Health? _____

Have you or your child ever had chiropractic care before ☐ YES ☐ NO

If yes, please tell us the doctor's name:_____

If yes, dates from: _____ to _____

Briefly describe your previous chiropractic experience: _____

_____

_____

Is your child receiving care from other health professionals? ☐ YES ☐ NO

If yes, please tell us the professional's name: _____

_____

_____

WHY this form is important:
As a full spectrum Chiropractic office, we focus on your child's potential for health. Our goals are to address the issues that brought you to our office and to offer your family the opportunity of improved health and wellness services in the future. Answering the following questions to the best of your ability will give us a profile of the specific stresses your child has faced, allowing us to better assess the challenges to their body. Reason(s) for consulting this office:

☐ 1. My child has no specific problem, I wish to use chiropractic to enhance their wellness, help them perform better, and allow them to live life at a higher level.

☐ 2. My child has a symptom(s) of a physical problem and I want to see if chiropractic will enable their body to work better.

If you checked box 2, fill out CURRENT HEALTH section below. If you checked box 1, skip to Health Survey.

What present complaint or persistent health challenge brings your child to our office?

_____

_____

Has your child had this type of problem before? ☐ YES ☐ NO Date of Onset: _____

If yes, how so? _____

_____

Have they seen anyone else for this problem? If so, how was it managed including medication?

_____

How is this affecting your life and theirs? _____

_____

Health Survey: *Check off any of the following symptoms your child has ever had.*

☐ Hyperactivity	☐ Insomnia/sleep problems	☐ Headaches
☐ Fatigue/poor sleep	☐ Irritability/Anxiety	☐ Bed-wetting
☐ Misbehaviour	☐ Digestive trouble	☐ Poor Balance
☐ Asthma/Respiratory issues	☐ Constipation	☐ Nervousness
☐ Colic	☐ Gas/Bloating	☐ Dizziness
☐ Poor focus/concentration	☐ Diarrhea	☐ Repetitive motion
☐ Muscle Stiffness	☐ Weakness	☐ Aggression
☐ Hyper/hyposensitivity	☐ Ear infections	☐ Colds/flus
☐ Poor motor control	☐ Poor posture	☐ Toe walking

☐ Other _____

Which of the above do you notice the most and how long has it been going on? _____

_____

Physical Stress or Challenges

History of Birth Born at: ☐ Home ☐ Hospital ☐ Birthing Centre Duration of gestation: _____ wks

Was birth assisted? ☐ Yes ☐ No If yes, How? ☐ Forceps ☐ Vacuum ☐ C-section ☐ Induced

Were medications given to the mother or baby at birth? ☐ Yes ☐ No If yes, what? _____

APGAR score at birth : _____ APGAR score after 5 minutes: _____

Child's birth weight _____ Child's birth height _____

Current Weight: _____ Current height _____

Please describe any childhood illnesses, hospitalizations, surgeries, serious falls, car accidents:

_____

_____

Average number of hours of TV/Computer per week? _____ hrs Weight of school backpack? _____lbs

Approx. hours spent playing per week? _____ hrs Does your child play sports? ☐ Yes ☐ No

Chemical Stress or Challenges

During pregnancy, did the mother:

Smoke	☐ Yes	☐ No	Become ill?	☐ Yes	☐ No
Drink alcohol or take drugs	☐ Yes	☐ No	Receive ultrasounds	☐ Yes	☐ No

Is your child currently taking any medication (over the counter and/or prescription)?

_____

Allergies or sensitivities?_____

Previous medications:_____

Is/was your child breastfed or formula fed? How long? _____

Any difficulties with latching or breastfeeding? ☐ Yes ☐ No If yes, explain _____

_____

Is/was your child able to latch on both sides equally? ☐ Yes ☐ No

Does your child consume sugar daily? ☐ Yes ☐ No

Is your child exposed to cigarette toxins daily? ☐ Yes ☐ No

Has your child received any antibiotics? ☐ Yes ☐ No

If yes, how many times and list reasons why: _____

_____

Did your child receive any vaccinations? ☐ Some ☐ All ☐ None Any reactions?

_____

How often is your child sick? _____

Please list any foods/juice intolerance: _____

Emotional Stress or Challenges

List any emotional/mental stressors presently in your child's life and any previous major stressors. (i.e. parents divorcing, bullying, bedwetting etc.)

_____

_____

Does your child have any behavior problems? Is so, have they been diagnosed?

_____

Goals

In your opinion, does your child seem normal for their age? ☐ YES ☐ NO

If no, please explain _____

What would you like your child to gain from chiropractic care? _____

_____

Are there other health concerns or anything else you'd like us to know about your child?

_____

Canadian Chiropractic Protective Association

Informed Consent to Chiropractic Treatment
FORM L

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 bums 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 option 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) Print Name

_____

Chiropractor Signature