



Many problems we see in adults have a start from the birth process itself or early on in life. It is often accumulated stresses and traumas that results in loss of health potential. Congratulations for making a pro-active health choice in getting your child evaluated for subluxations.

Child/Adolescent Introduction

Child's Name: _____ Address: _____
City: _____ Province: _____ Postal Code: _____
Phone: H:() _____ W:() _____ ext: _____ C:() _____
Birth Date: _____
Previous Chiropractor: _____ Present MD: _____
Whom shall we thank for referring you to our office? _____
Reason for consulting our office today? _____
Email Address (for important office announcements - hour changes, closures, holiday schedule, etc...no SPAM, we promise): _____ @ _____

Mainly For Moms

Did you carry full-term? _____ Any complications? _____

Please check all that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> used a mid-wife | <input type="checkbox"/> hospital birth | <input type="checkbox"/> had a C-section |
| <input type="checkbox"/> vacuum extraction | <input type="checkbox"/> forceps Extraction | <input type="checkbox"/> was induced |
| <input type="checkbox"/> had an epidural | <input type="checkbox"/> difficult birth | <input type="checkbox"/> deemed healthy birth |

Did you breastfeed? _____ How long? _____ Did you smoke? _____ Consume alcohol? _____

Any medications? _____ If so, what type? _____

Health History

As a baby/toddler, (birth to 4 years), did any of the following occur?

- | | |
|--|---|
| <input type="checkbox"/> Fall from a change table | <input type="checkbox"/> Frequent crying spells |
| <input type="checkbox"/> Tumble down stairs | <input type="checkbox"/> frequent fevers |
| <input type="checkbox"/> Fall out of crib | <input type="checkbox"/> frequent bouts of diarrhea |
| <input type="checkbox"/> Involved in car accident | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Play in "Jolly Jumper" | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> did not gain weight |
| <input type="checkbox"/> Reaction to vaccination | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Difficult breathing |

As a young child (5-12), did any of the following occur?

- | | |
|---|---|
| <input type="checkbox"/> Fall from a tree | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Fall of a bicycle | <input type="checkbox"/> Hyperactivity/Autism |
| <input type="checkbox"/> Fall of playground equipment | <input type="checkbox"/> Learning difficulties |
| <input type="checkbox"/> Sports accident | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Car accident | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Stomach pains | <input type="checkbox"/> Leg/knee pains ("growing pains") |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Other _____ |

Please check all that apply:

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Headaches / Migraines
- Tired / Fatigued
- Tight Muscles
- Fibromyalgia
- Tension across shoulders
- Stress
- Forgetfulness
- Liver/gall bladder problems
- High blood pressure
- Numbing-Tingling in Hands/Feet
- Numbing-Tingling in Arms/Legs
- Dizziness
- Ringing in Ears
- Nervousness
- Attention Deficit Disorder
- Frequent colds
- Difficulty Sleeping
- Thyroid problems
- depression
- Allergies / Sinus Problems
- Diarrhea / Constipation
- Asthma/allergies
- Menstrual Cramps
- Weight Trouble
- Foot / Ankle Pain
- Mood swings
- Upset stomach
- Ankle swelling
- Bladder trouble
- Heartburn
- Chest pain
- Walking problems
- Confusion
- Balance problem

My child participates in: computer work sports prolonged postures sleep face down

Please rate your commitment to resolving your child's problem(s)(10 being the highest): _____

Current Health History

Which of the problems you have checked off is the worst?

Is this problem: constant intermittent occasional cyclic

How long has it persisted? _____

When it is at its worst, how does it make your child feel? _____

What have you done about it that has NOT worked? _____

What makes it worse? _____ Better? _____

Does this upset your child? _____

Medical History

Any hospital stays? _____

Approximately how many times have antibiotics been prescribed, and for what conditions?

List any medications your child is currently taking? _____

To summarize, what is your purpose for this appointment? _____

Please note our fees for your initial visit:

Consultation	Complimentary
Examination	\$ 60.00
Radiology (If required)	\$ 60.00
Report of Findings	Complimentary

I fully understand the above fees and give my consent.

Parent SIGNATURE: _____ Date: _____

(Signature of parent/guardian required if patient under age 18)

Office use only: Health Pass Received

Your Informed Consent

Although Chiropractic is reported to be one of the safest health care systems in the world, there may be slight risks associated with it. We feel that it is responsible to let you know:

The risk of stroke has been reported to be approximately 1 in a million. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjusting and the occurrence of stroke;

While extremely rare, some patients may experience short term aggravation of symptoms; there have been reports of ligament sprains and rib fractures;

There have been rare reports of disc injuries although no scientific study has ever demonstrated chiropractic care to be the cause.

Chiropractic care has been proven to be both clinically and cost effective. The risk of injuries and complications is so small that chiropractors carry one of the lowest malpractice insurance premiums of all the health care professions. Chiropractic care contributes to your overall well being. Compared to traditional medical/drug/surgical care, Chiropractic is one of your safest health care systems.

Chiropractic is not a treatment for any disease or condition, but a healing art that removes interference to your healing capabilities. Our focus is primarily removing interference to your nervous system through chiropractic adjustments.

I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor. I consent to the examination and care recommended by my chiropractor and extend this consent to include all doctors of this facility. I intend this consent to apply to all present and future care for myself and my family.

Dated this _____ Day of _____, 20_____.

Patient Name (please print)

Patient Signature (Legal Guardian)

Name of Witness (please print)

Witness Signature

Privacy Policy (this document is a summary of our privacy policy)

Privacy and sensitivity of personal health information is an important principle in the office of Dr. Jonathan Saunders. We are committed to collecting, using and disclosing personal health information responsibly and confidentially and only to the extent necessary for the goods and services we provide. We also try to be open and transparent as to how we handle health information.

This office will collect, use and disclose information for the following purposes: access your health care needs and advise of your options. This may include consultation, examination, diagnosis/differential diagnosis, prognosis, recommendations and referral; obtain a baseline of health and social information; establish credit or goods/services and properly invoice;

Personal health information includes information that relates to your personal characteristics, health or activities and views. Personal health information is to be contrasted with publicly available information and business information, which is not protected by privacy legislation.

Dr. Jonathan Saunders will protect personal health information, by security safeguards appropriate to the sensitivity of the information. Safeguards will vary depending on the sensitivity, format (paper/electronic) and storage of the personal health information.

We need to retain personal health information for some time to ensure that we can answer any questions you might have about the services provided and for our own accountability to external regulatory bodies. However, we do not want to keep personal health information too long in order to protect your privacy.

Personal health information can only be used or disclosed for the purpose for which it was obtained. In most cases, we shall ask an individual to specifically consent in writing, but in some circumstances, we may accept your verbal consent with/without documentation. Under certain circumstances, we will use and disclose personal health information without consent for example in the case of medical emergency. Subject to certain legal, contractual resolutions and reasonable notice, you may withdraw your consent at any time.

Access to summary of an individual's personal health information held by Dr. Jonathan Saunders is available upon request. We can help you identify what records we might have about you. If we can not give you access, we will tell you within 30 days if at all possible and tell you the reason and possible recourse that is available. If you believe there is a mistake in the information, you have the right to ask for it to be corrected.

SIGNATURE: _____

DATE: _____