ASCENT
INTEGRATIVE HEALTH

Youth (6-12 Years) Chiropractic Patient Intake Form

To allow us to provide you with the best possible care, please complete this form as thoroughly as possible.
All information is strictly confidential.

Patient Information

Date: _____ Sex: □ Male □ Female E-mail:_____

Child's Name: _____ Preferred Name: _____

Mother's Name: _____ Father's Name: _____

Street Address: _____ Postal Code: _____ City: _____ Prov: _____

Home Phone: _____ Cellphone: _____ Work: _____

Age: _____ Birthdate: (D) ____ / (M) _____ / (Y) _____ Weight: _____ Height: _____

School Grade Level: _____ Alberta Health Care Number: _____

**We communicate appointment reminders, invoices, receipts, exercise programs & health tips via email. We hate spam, but we really value educational information. Do we have permission to utilize your email address?* □ Yes □ No

Medical Information

Family MD/Pediatrician's Name: _____ Clinic: _____

Date of last MD visit: _____ Reason: _____

What therapy has your child previously received? □ Chiropractic □ Massage □ Physiotherapy

**Communication between healthcare providers can greatly improve the quality and safety of patient care. If necessary, do you consent to allow your health provider at PHP to contact your medical doctor?* □ Yes □ No

Extended Health Benefits & Other Insurance

Do you have a private insurance plan? □ No □ Yes (Self) □Yes (Spouse) □Yes (Parent)

Name of primary policy holder (Spouse/Parent): _____

Which company? □ Alberta Blue Cross (ABC) □ SunLife □ Great West Life □ Green Shield

□ Standard Life □ SSQ Financial □ Desjardins □ Chamber of Commerce □ Cowan □ Industrial Alliance

□ Johnson □ Manulife □ Other: _____

Policy No: _____ Member ID: _____ Group No: *(*ABC Only)* _____

Is this a Motor Vehicle Accident Case (MVA)? □ No □ Yes Date of the Accident: _____

How Did You Find Us?

□ Referred by Friend/Family □ Referred by Medical Doctor □ Internet/Website □ Street Sign

□ Referred by Trainer □ Walk In □ Health Care Event □ Other: _____

**Whom may we thank for this referral? _____

Current Health Condition

Primary Complaint/Purpose of Appointment: _____

When did this begin? _____

Has your child had this before? □ No □ Yes; when: _____ Is it getting: □ Worse □ Better □ Not Changing

Is the condition: □ Auto-Related □ Sports-Related □ Fall □ Other: _____

Has your child seen anyone else for this condition? □ No □ Yes: _____

Has your child had any imaging for this condition? □ X-Ray □ CT □ MRI □ Ultrasound Date: _____

Is your child presently taking any medications/supplements? _____

Are there any secondary complaints/conditions? _____

_____

General Health History

Any Known Health Conditions/Illnesses: □ No □ Yes; list: _____

Childhood Diseases? □ Mumps □ Measles □ Chicken Pox □ Small Pox □ Diabetes □ Pneumonia □ Asthma

Big Falls or Injuries: □ No □ Yes; List: _____

Hospitalizations/Surgeries: □ No □ Yes; list: _____

Fractures: □ No □ Yes; Where/When: _____

Any Allergies: □ No □ Yes; list: _____

Vaccination History: _____

Family History

Is there a family history of:	Heart Disease	Stroke	Cancer	Diabetes	Arthritis	Other
*Mother's Side:	□	□	□	□	□	_____
*Father's Side:	□	□	□	□	□	_____

Lifestyle

Does your child participate in sports/exercise regularly? □ No □ Yes; Type/Frequency: _____

_____

Does your child have a healthy & balanced diet? □ No □ Don't Know □ Yes, I think so □ Yes, definitely

What are you child's daily stress levels? □ Extreme □ High □ Moderate □ Low □ Very Minimal

What is your child's quality of sleep? □ Excellent □ Fair □ Poor Hours per night? _____

Health Status Survey

Please check the box for any conditions or symptoms that your child has had in the ***past six months:***

□ Sore Muscles
□ Sore Joints
□ Growing Pains
□ Muscle Cramps
□ Back Problems
□ Neck Problems
□ Pain b/w Shoulders
□ Spinal Curvature
□ Leg Pain
□ Arm Pain
□ Walking Problems
□ Feet Turn In/Out
□ Coordination Problems
□ Clumsiness
□ Headaches
□ Fatigue
□ Difficulty Sleeping
□ Dizziness
□ Fainting
□ Loss of Weight
□ Poor/Excessive Appetite
□ Nervousness
□ Depression/Confusion
□ Hyperactivity
□ Behavioral Problems
□ Epilepsy
□ Numbness/Tingling
□ Seizures
□ Earaches/Infections
□ Sore Throat
□ Stomach Aches
□ Diarrhea
□ Constipation
□ Eczema
□ Slow Weight Gain
□ Bedwetting

ASCENT
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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