Information reviewed with parent/guardian

Dr. Initials _____

**Brisbin Family Chiropractic**

Today's Date_____

## PATIENT INFORMATION (PEDIATRIC INTAKE – AGES 6-12YRS)

Patient Name_____

Address_____

City_____ Postal Code_____

**Alberta Health Care #**_____

Gender _____ Age_____

Date of birth_____

**IN CASE OF EMERGENCY, CONTACT**

Name_____

Relationship_____

Contact Number_____

Mother's Name _____

Mother's Occupation_____

Mother's Phone #_____

Father's Name_____

Father's Occupation_____

Father's Phone #_____

Email _____

☐ I do not want to be contacted via email

Who may we thank for referring you?

_____

## HOW CAN WE HELP YOUR CHILD?

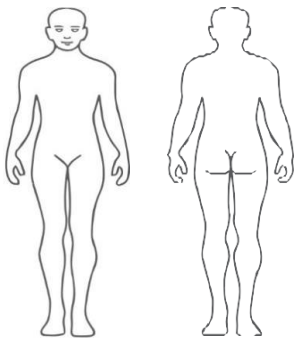
☐ Wellness Checkup

☐ Other (Specific concern) _____

If your child is already experiencing symptoms, please describe:

_____

Please circle areas to the right where your child has pain or other symptoms: →



Does you child's symptoms/stresses/behaviors impact your family's well-being and ability to function in social settings? ☐ Yes ☐ No

Has anyone assessed your child's nervous system before? ☐ Yes ☐ No

Has your child been treated by a chiropractor in the past? ☐ Yes ☐ No

If yes, when and for what reason?_____

Is this related to a Motor Vehicle Accident **in the last 10 days**?

☐ No ☐ Yes, date of accident _____

## PREVIOUS INJURIES

Has your child ever had any of the following? (check all that apply and describe)

☐ Head Injuries_____ ☐ Concussions_____

☐ Motor Vehicle Accidents_____

☐ Broken Bones_____

☐ Surgeries_____

☐ Sports Injuries_____

☐ Hospitalizations _____

## CHILDHOOD ILLNESSES

Has your child ever suffered from (check all that apply)?

- ☐ Allergies
- ☐ Anemia
- ☐ Arm Pain
- ☐ Asthma
- ☐ Back Aches
- ☐ Bed Wetting
- ☐ Behavioral problems
- ☐ Broken Bones
- ☐ Chronic Ear Infections
- ☐ Cold/Flu
- ☐ Colic
- ☐ Seizures
- ☐ Delayed Speech
- ☐ Diabetes
- ☐ Constipation
- ☐ Upset stomach
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Heart Conditions
- ☐ Hyperactivity
- ☐ Poor sleep
- ☐ Juvenile Arthritis
- ☐ Joint pains
- ☐ Leg Pains
- ☐ Neck Pain
- ☐ Growing pains
- ☐ Scoliosis
- ☐ Paralysis
- ☐ Poor Appetite
- ☐ Hernias
- ☐ Sinus infections
- ☐ Tuberculosis
- ☐ Walking Problems

## SCHOOL

Does your child experience any of the following school-related concerns?

- ☐ Behavioral Issues
- ☐ Diagnosis of ADHD
- ☐ Diagnosis of Autism Spectrum Disorder
- ☐ Learning Difficulties
- ☐ Difficulty reading/writing/spelling
- ☐ Delayed verbal communication
- ☐ Anxiety
- ☐ Tension/stress headaches
- ☐ Difficulty Concentrating
- ☐ Poor posture
- ☐ Growing pains
- ☐ Sleep Issues
- ☐ Vision Changes

How many hours of screen time per day does your child have? (tv/phone/tablet/video games)

☐ <1 hour ☐ 1-2 hours ☐ 2-3 hours ☐ >3 hours

How often does your child work at a computer? (at home and at school)

☐ <1 hour ☐ 1-2 hours ☐ 2-3 hours ☐ >3 hours

How much physical activity per day does your child have?

☐ <30 minutes ☐ 30 - 60 minutes ☐ 1-2 hours ☐ >2 hours

## ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

Allergies (list)

_____

_____

Medications (list)

_____

_____

Surgeries (list)

_____

_____

Family History (list)

_____

_____

# CONSENT TO CHIROPRACTIC TREATMENT

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 the 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 with only last 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 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.

_____

Name (Please Print)

_____ Date:_____20_____

Signature of patient (or legal guardian)

_____ Date:_____20_____

Signature of Chiropractor