Gibsons Chiropractic, Health & Wellness Centre®

Todays Date: _____

Pediatric Patient Intake & Assessment Form

PERSONAL

Name:_____
(Last) (First) (Middle)

Address:_____ **Postal Code:**_____

Parent's Name(s):_____ **School Attended:**_____

Telephone Number:(_____**)**_____ (Home) **(**_____**)**_____ (Cell)

Emergency Contact Name(s) if different than above**:**_____ **Telephone: (**_____**)**_____

Email:_____ **Permission to send email/text appt. reminders & e-newsletter?**_____ (Y or N)

Birthdate:_____ (MM/DD/YYYY) **Age:**_____ **Sex:**_____ (F or M) **Siblings?**____ (Y or N) **If yes, how many?**_____

CareCard Number:_____ **Private Health Insurance:**_____

How was your child referred to our Clinic?_____

HEALTH

Has your child had previous Chiropractic care?_____ (Y or N) **By Whom?**_____ **When?**_____

Has your child had X-rays taken?_____ (Y or N) **If yes, Date Taken:**_____ **Area/Results:**_____

Medical Doctor:_____ **Do you consent to the findings being shared with your Medical Doctor?**____ (Y or N)

PRIMARY AREA OF CONCERN:

Please indicate on the diagram on the right where your child has pain/symptoms

Describe the area of concern/pain (tingling, numb, sharp, burning, tender, stiff, sore, etc.):_____

_____

_____

How did your child's problem begin?_____

_____

_____

Rate your child's pain/discomfort: Please have your child indicate on the face diagram below how severe their pain/discomfort is

Does your child have (had) any of the following conditions?

- ☐ Muscular Dystrophy
- ☐ Epilepsy
- ☐ Down's Syndrome
- ☐ Autism Spectrum
- ☐ ADD/ADHD
- ☐ Congenital/genetic disorder
- ☐ Diabetes
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Polio
- ☐ Lupus
- ☐ Psoriasis
- ☐ Eczema
- ☐ Aneurysm
- ☐ Heart conditions
- ☐ Anemia
- ☐ Blood Pressure
- ☐ Colic
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Allergies
- ☐ Sinus conditions
- ☐ Loss of smell
- ☐ Ear infections
- ☐ Tubes in ears
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Dizziness
- ☐ Concussion
- ☐ Loss of balance
- ☐ Fainting
- ☐ Fatigue
- ☐ Sleeping difficulty
- ☐ "Nerves"/Anxiety
- ☐ Irritability
- ☐ Persistent/unexplained crying
- ☐ Intestinal gas/bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Liver conditions
- ☐ Kidney conditions
- ☐ Bedwetting
- ☐ Bladder/Urinary Tract Conditions
- ☐ Unexplained/persistent fever
- ☐ Headaches
- ☐ Migraines
- ☐ Head feels too heavy
- ☐ Vision problems
- ☐ Wearing glasses
- ☐ Light bothers eyes
- ☐ Flushing of face
- ☐ Twitching in face
- ☐ Jaw clicking
- ☐ Clicking in neck
- ☐ Clenching/grinding teeth
- ☐ Muscle spasms
- ☐ Torticollis/Wry neck
- ☐ Tight neck/shoulder muscles
- ☐ Back pain
- ☐ "Growing" pains
- ☐ Scoliosis (abnormal spinal curvature)
- ☐ Painful joints
- ☐ Arthritis
- ☐ Pins & needles in hands/feet
- ☐ Swollen hands/feet
- ☐ Cold hands/feet
- ☐ Numbness
- ☐ Broken bones
- ☐ Dislocated joints
- ☐ Incoordination
- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Whooping Cough
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Croup
- ☐ Rheumatic Fever
- ☐ Typhoid Fever
- ☐ Chronic illness_____
- ☐ Other_____

BIRTH INFORMATION:

Vaginal delivery or C-section?_____ **Anesthesia used?**_____ (Y or N) **If yes, what type**_____

Total hours of labour:_____ **Where did the birth take place?**_____

Birth incidents, intervention, or trauma?_____

_____

Has your child had any falls or injuries?_____ (Y or N) **If yes, when?**_____

Please explain _____

_____

Has your child ever had surgery?_____ (Y or N) **If yes, when?**_____

Please explain _____

Is your child taking any medication?_____ (Y or N) **If yes, please give name, dosage, & what it is for**_____

_____

One full day's notice is required for cancellation of appointments

_____
(Patient's Initial)

Health Objectives Questionnaire

What are your child's health objectives? _____

_____

Has your child ever been put on a health development program by a health practitioner?

☐ Yes ☐ No If yes, by whom _____

How long was he/she you able to stay on the program? _____

What was his/her results? _____

_____

If applicable, is your child healthier today than he/she was 5 years ago?

☐ Yes ☐ No ☐ Health has not changed

If yes, what have you done to improve his/her health? _____

_____

If no, why do you think his/her health has declined? _____

_____

Do you think your child's health will be better in 5 years from now than it is today?

☐ Yes ☐ No ☐ I don't expect it to change

If yes, what do you plan to do to improve his/her health? _____

_____

Do you think there is anything you can do to prevent your child's health from declining? _____

Please elaborate further _____

_____

_____

Does your child exercise and stretch regularly?

☐ Yes ☐ No

If yes, what do you do, how often, and how long? _____

Does your child currently wear orthotics?

☐ Yes ☐ No

If yes, type and how long?_____

 Todays Date: _____

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 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 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 stoke 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 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

CCPA 12/2014

 Todays Date: _____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept such a patient for care, it is essential for both to be working towards the same objectives. Chiropractic has only one goal: to eliminate spinal misalignments (subluxations) that interfere with the body's natural healing ability. The Chiropractor's sole purpose is to restore health through the natural flow of energy in the nervous system, to give the body the maximum opportunity to heal itself.

It is important to understand what to expect from chiropractic in order for you, the patient, to determine whether it may be of benefit to you. A Chiropractor conducts a specialized spinal examination and analysis for the express purpose of determining whether there is evidence of spinal subluxations. When such subluxations are found, chiropractic adjustments are given to restore proper spinal alignment and function. Due to the complexities of nature, no Chiropractor can promise you specific results – this depends on the recuperative powers of your body. We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what this disease is called, we do not offer to treat it. Nor do we offer advice on the treatment prescribed by others. Every chiropractic patient should be mindful of his/her own symptoms and should secure a medical opinion if he/she has any concern as to the nature of his/her illness or injury. In rare cases, underlying physical defects, deformities, or pathology may render the patient susceptible to injury. The Chiropractor, of course, will not give a chiropractic adjustment if he/she is aware that such a condition exists. It is the responsibility of the patient to make it known if he/she is suffering from any latent pathological defects, illness, or deformity that might not otherwise come to the attention of the Chiropractor. The patient should not look to the Doctor of Chiropractic for in-depth diagnostic procedures other than to find subluxations. This is the most important difference between chiropractic and medicine.

Our only practice objective is to promote natural health through the release of maximum nerve energy. Our only treatment is by specific chiropractic adjustments to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
PRINT NAME

All questions regarding the Chiropractor's objectives pertaining to my care in this office have been answered to my satisfaction.
I, therefore, accept chiropractic care on this basis.

_____ _____
SIGNATURE DATE

If applicable, _____
SIGNATURE OF PARENT OR GUARDIAN

 Todays Date: _____

Assignment Of Medical Services Plan Benefits To Opted-Out Practitioners

I, _____(Beneficiary) authorize the Medical Services Plan of BC to pay **Dr. Stacey Michelle Rosenberg, D.C.** (Practitioner) directly for all reimbursements for benefits payable to me under the Medical and Health Services Regulation for care provided to me by said Practitioner.

I make this assignment in full knowledge of the amount that I will be personally responsible for and the amount that is reimbursable by the Medical Services Plan of BC, which will be directed to **Dr. Stacey Michelle Rosenberg, D.C.** (Practitioner) to be applied against any outstanding monies I owe for services provided.

MSP Practitioner#: 21127 MSP Payment#: 21127

Name of Patient: _____ (Please Print)

PHN of Patient: _____ (Care Card Number)

Dear Patient:

This form allows the above named practitioner to receive your MSP reimbursement directly for services that are MSP benefits. Your practitioner, by law, must advise you of his/her full fee and what portion will be reimbursed by MSP. By agreement, your practitioner may not charge you the portion reimbursed by MSP.

Signature of Patient/Guardian: _____

Date Signed: _____

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