**DOUGLASDALE FAMILY CHIROPRACTIC CENTRE**

Youth Introduction Form (7-17 years)

Today’s Date:

|  |  |  |  |
| --- | --- | --- | --- |
| Last name: First name:AHC#:Date of birth: Current age: Gender:Current grade: School:Parents names: |                                                                                                                                                                                                                                                                                                                                                           Male Female                                                                                                                                                                                                                         | Address: City: Province: Postal code:Home phone number:Cell phone number:Parents cell phone numbers:Parents Email: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you ever seen a Chiropractor? If yes, who with & date of last visit:                                                                                                          How was your previous Chiropractic experience?                                                                                                                                        Who referred you to our office?                                                                             **Physical History**Reason for seeking care**: Wellness checkup Maintenance Specific Symptom Auto Accident**If you current have a specific symptom, what is it?                                                                                                                                   What date did the specific symptom appear?                                                                       How long has it been since you really felt good?                                                                                                                                          What is the goal you’d like to achieve by having your health restored?                                                                                                                                                                                                                                                               Please list any of the following injuries and their dates:

|  |  |
| --- | --- |
| Auto:                                                                        | Work:                                                                        |
| Sports:                                                                        | Other:                                                             |

Is this condition getting progressively worse? Yes No Constant Comes and GoesDoes it interfere with your: School Sleep Daily Routine Ability to enjoy lifeDo you currently use orthotics? Yes NoHospitalizations or surgeries: No Yes Explain:                                                                       Do you play sports? No Yes Explain:                                                                       School backpack: Heavy Light Carried on one shoulder? Yes No Any secondary complaints?                                                                                 **Chemical History**Please list any vitamins or supplements you are taking:                                                                                                           Have you ever been vaccinated: No Yes Comments:                                                     Any reactions to vaccines?                                                                                                                                                        Are you taking medications or antibiotics? No Yes Explain:                                                           **Emotional History**  Please let us know about any recurring stress, loss or abuse in your life that we need to be made aware of:                                                                                                                                                                                                      |

*Your personal information will be held in the strictest confidentiality and is used only for the clinical purposes at Douglasdale Family Chiropractic. If you have any areas that you are not comfortable discussing or that require further confidentiality, please speak directly to the Doctor about them.*

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Have you ever suffered from or are currently suffering from any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Dizziness | Diabetes | Bleeding Nose | Jaundice |
| Anemia | Poor Appetite | Bed Wetting | Fainting |
| Backaches | Neck Problems | Joint Problems | Tuberculosis |
| Headaches | Digestive Disorders | Rheumatic Fever | Hyperactivity |
| Convulsions | Walking Problems | Arm Problems | Blood Disorders |
| Heart Trouble | Hypertension | Asthma | Sinus Trouble |
| Orthopedic Problems | Sugar Concentration | Paralysis | Broken Bones |
| Leg Problems | Stomach Aches | Chronic Earaches | Colds / Flus |
| Allergies | Constipation | Diarrhea | A.D.D. |
| Behavioural Problems | Muscle Jerking | Ruptures / Hernias | “Growing Pains” |

Other:

|  |  |
| --- | --- |
| Parents Signature:                                                                                       Youths Signature:                                                                                      |  Date:                                                                           Date:                                                                        |

Please do not write in the space - for office use only

**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:

1. 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;
2. 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. Recent studies suggest 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;
3. 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;
4. There are infrequent reported cases of burns 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 options 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) Witness Signature**

 **Name (Please Print) Witness Name (Please Print)**

CCPA12.08 (ENGLISH)