Dynamic Balance Chiropractic
Pediatric New Client Questionnaire

1. Please fill in the following Pediatric Patient Information:

Patient Name_____ Date_____

☐ Male ☐ Female Date of Birth (mm/dd/yy) _____ Age_____

Address_____ City_____ Province_____ Postal Code_____

Client's Hobbies and Interests _____

Whom may we thank for referring you to our office? _____

Why did you choose this office? _____

What are your expectations from working with us? _____

Parent/Guardian Contact Info: Name: _____

Cell Phone_____ Work/Home Phone_____

Email_____ Best time to reach you_____

Occupation_____ Employer_____

In case of emergency, other contact: _____Phone_____

Are you: ☐ Single ☐ Married / Common Law ☐ Widowed ☐ Separated ☐ Divorced

Spouse/Partner Name_____

(Parent/Guardian) Are you pregnant? ☐ No ☐ Don't Know ☐ Yes, approximate due date_____

Other Children's Names and Ages

1. _____ Age: _____
2. _____ Age: _____
3. _____ Age: _____
4. _____ Age: _____

2. Please tell us more about the current situation for this child:

Is something currently keeping your child from experiencing and enjoying life as much as they would like?

☐ No, We are here for continued health development and/or the ongoing pursuit of wellness.

☐ Yes, he/she has symptoms. (please list them below, in order of their effect on your life)

1. _____ How long has this affected their life? _____
2. _____ How long has this affected their life? _____
3. _____ How long has this affected their life? _____

Please list any drugs or medications currently taken by this child:_____

_____

Please list any surgeries or hospitalizations this child has had:_____

_____

What else stands in the way of full expression of their potential? _____

_____

Has this child ever been to a Chiropractor before? ☐ No ☐ Yes: _____

Please list any other health care professionals they are currently seeing:_____

_____

Who is the child's medical doctor? _____

Address/ Phone: _____

Are you satisfied with the current perceived overall health status of this child? ☐ Yes ☐ No

3. Family History

(Parent/Guardian) Do you or anyone else living with this child smoke?

☐ No ☐ Occasional ☐ Daily: ____ packs/day ☐ I want to quit.

Please check if any of these conditions were experienced by this child's family members: ☐ Don't know

	Mother	Father	Siblings
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐
Cancer	☐	☐	☐
Arthritis	☐	☐	☐

Other family history that you feel is important:_____

4. Are you seeking care for this child as a result of an accident? ☐ Yes ☐ No (If no, please skip to sect. 6)

Date of Accident_____

Type of Accident: ☐ Auto ☐ Other_____

Details: (How did it happen?) _____

_____

5. Child's Daily Habits (<u>skip any questions that do not apply</u>)

On average, how many hours of quality sleep does this child get per day? _____

Child's exercise: ☐ Heavy (Competitive Sports) ☐ Daily (4-7 days/wk) ☐ Moderate (1-3 days/wk) ☐ None

Total average amount of time this child spends watching TV, playing video games or using a computer:

☐ None ☐ 1-3 hours/day ☐ 4-6 hours/day ☐ 7-12 hours/day ☐ More than 12 hours/day

How often does this child consume:

Caffeine drinks:	☐ Never	☐ Occasional	☐ Daily
Sugars/sweets:	☐ Never	☐ Occasional	☐ Daily
Dairy Products:	☐ Never	☐ Occasional	☐ Daily
Wheat Products:	☐ Never	☐ Occasional	☐ Daily
Fruits/Vegetables:	☐ Never	☐ Occasional	☐ Daily
Water as a beverage:	☐ Never	☐ Occasional	☐ Daily

Please list any Vitamins/Herbs/Minerals the child takes:_____

6. Has this child ever:

☐ Been in a car accident ☐ Been diagnosed with cancer ☐ Been diagnosed with another condition:

☐ Had a spinal cord injury ☐ Had spinal surgery _____

7. Responsible Party

Who is responsible for decisions related to the care of this patient?

1. Name:_____ Relationship_____ Phone_____
2. Name:_____ Relationship_____ Phone_____

8. Payment for services rendered

To best serve you, we operate our office under the guidelines of "payment at the time of service". This allows our staff to focus their time and energy on your health care needs, and minimizes administrative efforts. This allows us to keep our costs (and yours) at a reasonable level. Thank you for honoring this system and fulfilling your financial obligations at the time that the services are performed.

The above information is true, complete and accurate to the best of my knowledge.

Parent/Guardian Signature:_____ Date:_____

BIRTH HISTORY

Please fill in the details of the pregnancy:

Were any fertilization aids used in this pregnancy (IVF, etc.)? No ☐ Yes ☐ _____

Were there any complications or issues during pregnancy? No ☐ Yes ☐ _____

LABOR AND DELIVERY

How long was the term of pregnancy for this child?_____

How long was the labor from the first regular contractions to birth? _____ hours

How long was the Second stage (the pushing phase) of the labor? _____ hours

	Yes	No	Notes
Hospital Birth			
Home Birth			
Midwife Assisted			
Vaginal Delivery			
Planned C-Section			
Emergency C-Section			
Was birth Induced (Pitocin)			
Epidural			
Forceps delivery			
Vacuum extraction			
Medications administered			
Fetal Distress			
Meconium staining			
Head Presentation			
Face Presentation			
Breech Presentation			

BABY'S CONDITION IMMEDIATLEY AFTER BIRTH

Birth weight_____lbs____oz Birth length _____in Baby home on day _____

Apgar score At 1 minute_____/10 At 5 minutes_____/10

Baby's Crying Baby cried immediately after birth ☐

Strong Cry ☐ Weak Cry ☐ Did not cry for ____minutes

Baby's colour Pink all over ☐ Blue Face ☐ Blue hands/feet ☐

Baby's activity Arms and legs actively moving ☐ Floppy baby ☐

Intensive care Was required ☐ Days in NICU _____

Medication given at birth?_____

Vaccines administered_____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

We use a multitude of techniques and tailor the care of our patients and practice members to their individual needs and limitations. We take great care to maximize results while minimizing risks. In pediatric cases, this is especially important. However, as in all forms of care and treatment, some risk is inevitable and unavoidable. Our Clinic is dedicated to assisting you in recovering your health naturally. Please review the following paragraphs and sign in the area provided.

I understand and agree that extended health benefits and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment to the Doctor. All fees are due at time of service unless otherwise arranged with the clinic directors in writing.

I hereby request and consent to the performance of Chiropractic examinations, adjustments and other chiropractic procedures such as diagnostic x-rays performed on my child by the doctor of chiropractic and/or anyone working in this clinic authorized by the doctor of chiropractic or at an external imaging facility to which I am referred.

I have had an opportunity to discuss with the doctor of chiropractic/staff members and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including but not limited to, muscle strains and sprains, disc injury and stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my child's best interest.

I acknowledge that I have had the opportunity to discuss with my chiropractor the nature and purpose of chiropractic treatment in general and my child's treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I understand that when I schedule an appointment for services at Dynamic Balance Chiropractic, that time is reserved for me/my child and is not available to other clients. I understand that cancelling with less than 24 hours notice, or failing to appear for my scheduled appointments will result in me being charged for the services for which I am/my child is scheduled. I understand also that my insurance company will not reimburse me for "no-show" charges.

I consent to the chiropractic treatments offered or recommended to me/my child by the chiropractor, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care. I reserve the right to withdraw my consent at any time with verbal or written notice of such a decision.

Email is used in our office to communicate with patients and to send our free monthly wellness newsletter.

□□ I do not want any email from Dynamic Balance Chiropractic, including content regarding appointment reminders or changes, invoices for insurance reimbursement, or care recommendations.

□□ I know I can unsubscribe at any time, but I do not wish to receive the free monthly wellness newsletter from Dynamic Balance Chiropractic.

Parent/Guardian Signature: _____

Print Parent/Guardian Name:_____

Date:_____

Signature of Witness:_____
(employee at Dynamic Balance Chiropractic)

Print Witness Name:_____

Date:_____