Dynamic Balance Chiropractic
Pediatric New Patient Questionnaire

1. Please fill in the following Pediatric Patient Information:

Patient Name_____ Date_____
□Male □Female Age_____ D.O.B._____
Address_____ City_____ Province_____ Postal Code_____
Patient's Hobbies and Interests _____
Whom may we thank for referring you to our office? _____
Parent/Guardian Contact Info: Name: _____
Home Phone_____ Work/Cell 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_____ D.O.B_____

(Parent/Guardian) Are you pregnant? □No □Don't Know □Yes, approximate due date_____
Other Children's Names and Ages
1. _____ Age: _____ 3. _____ Age: _____
2. _____ Age: _____ 4. _____ Age: _____

2. Please fill in the details of the pregnancy and birth of this child:

Were any fertilization aids used in this pregnancy (IVF, etc.)? □No □Yes:_____
How long was the term of pregnancy for this child? _____
Were there any complications or issues during pregnancy? □No □Yes:_____
How long was the mother in labor? _____
Was the birth of this child induced medically? □No □Yes
Were any medications used during labor or delivery? _____
Any other interventions performed: (please circle)
Epidural Caesarean section Vacuum extraction Other:_____

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

Why did you choose this office? _____
What are your expectations from working with us? _____

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 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

4. 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:_____

5. 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?) _____

_____

6. Child's Daily Habits (skip any questions that do not apply)

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:_____

7. 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 _____

8. Responsible Party

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

1. Name:_____ Relationship_____ Phone_____

2. Name:_____ Relationship_____ Phone_____

9. 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:_____

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. In chiropractic care, some of the associated risks are listed below:

- As we seek to make changes in the way your child's body works, sometimes patients may experience a short term aggravation of their symptoms, muscle strains, or ligament sprains. If they have symptoms, they may get worse before they get better. This is especially rare in children because of the conservative methods we use.
- There are reported cases of cerebrovascular incidents or stroke that have been associated with many common neck movements, including painting a ceiling, backing up a car, having your hair washed at a salon, and manipulation of the cervical spine. The most up to date research does not show a causal relationship between chiropractic adjustment and stroke, and none of the reports have involved pediatric patients. We are, however, required to inform you of these reports. The possibility of such injury to happen after a visit to a chiropractic office has been shown to be the same as a visit to a medical office, and is extremely remote. No reputable study has shown that a stroke was caused by a chiropractic adjustment. We screen each patient for risk factors of stroke and modify our treatments to reduce risk of any sort.

Pediatric patients are treated significantly different than adults because their bodies are different. Care for newborns, toddlers and children is very gentle and specific.
Chiropractic treatment and chiropractic adjustments have been the subject of many government reports and interdisciplinary studies conducted over the last 115 years, and have been demonstrated to be safe and effective. Chiropractic care also contributes to your overall well being, and the risks of injuries or complications from chiropractic treatments is substantially lower than many other forms of treatment.

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 adjustments) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to my child by their 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 correspondence is often used in our office to communicate with patients as well as to send our free monthly wellness newsletter.

☐ I do not want any email from Dynamic Balance Chiropractic, even regarding appointment changes, invoices for insurance reimbursement or care recommendations.

☐ I know I can unsubscribe at any time, but I do not want 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:_____