

Pickering Chiropractic Health Centre

Introduction To The Office

Welcome

We want to extend a warm and personal welcome to you on behalf of all of us at the Pickering Chiropractic Health Centre. We want to provide you with the finest health care and we will offer you many informative and entertaining educational opportunities.

Why?

Firstly, you'll want to make informed decisions regarding your health. During the course of your care you'll be presented with several choices that will affect your ability to reach your individual health objective.

Secondly, this information will be useful in making decisions about your health for the rest of your life.

To begin this process, here are a few important terms and procedures as you begin care:

First Visit

On your first visit we will gather information about you through our examinations and consultations. There will be someone here to assist you in each step along the way. If you're not sure about what we need, just ask. Nothing will be done without your consent and full understanding.

Patient Education

We will be giving you information and clinical data in the form of literature, personal and media presentations. These are designed to help you understand your own case and the procedures you'll experience in this office. Everything is brief and to the point. It is recommended that you read the material and keep it together for reference during the course of your care.

Chiropractic Education

Just as we need to know about you, you should know about us. Chiropractic education currently consists of four years of university education in the biological sciences, followed by another four years of Chiropractic education and clinical internship. Then we are required to attend many hours of post-graduate education each year for license renewal. On top of this, our office is frequently involved in various seminars to keep abreast of the latest information.

Paperwork and Forms

We have minimized paperwork in our office. However, there are clinical forms that must be filled out accurately for health, legal and professional reasons. We ask that you read a form through before completing it so you understand its intent. If you have questions, please ask.

Health Attitudes

Your attitude about your health is as important to us as the specific reason you've consulted our office. Below are four prevalent health attitudes. Please mark the one that most closely reflects your personal values.

- **Treatment only.** I only consult a doctor when I have an ache or a pain and discontinue care as soon as it has cleared up.
- **Prevention.** In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring.
- **Maintaining Health.** I'm conscious about my health, diet and exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential.
- **Family Health.** I take an active part in assisting, informing, and maintaining health, with my family. I'm concerned with the long-term affects of good health.

Thank you. And again, we look forward to a healthy relationship with you.

Personal Information

Name _____ Date _____

Address _____ City _____ Postal Code _____

Phone: Res. _____ Bus. _____ Cell _____

E-mail address: _____

Date of Birth (D/M/Y) _____ Age _____

Referred by _____

Student _____ Other _____

Mother's name: _____

Father's name: _____ # of Siblings & ages _____

Have you ever received Chiropractic Care? Yes / No

M.D. Name and Address _____

_____ Postal Code _____

May we communicate with your M.D. concerning your health? Yes / No

Pickering Chiropractic Health Centre



Initial Child & Adolescent Questionnaire

Your Name: _____, Your Mom: _____

Your Dad: _____

Mainly for Moms:

1. Tell us about your pregnancy;

Did you carry to full term? _____

Describe any complications and when they occurred: _____

2. Tell us about your delivery and birth of this child:

Did you use a midwife? _____ Hospital? _____ Obstetrician? _____

Did you have a C-Section? _____ Were forceps used? _____

Vacuum Extraction? _____ Were you induced? _____

Did you have an Epidural? _____ Was it a difficult birth? _____

What was the baby's **APGAR** Score? _____ at 5 minutes? _____

3. Tell us more:

Did you breastfeed? _____ How long? _____ What formula after? _____

Did you consume alcohol during your pregnancy? _____ How much? _____

Did you smoke? _____ How much? _____ How long? _____

Did you take any medication during your pregnancy?

For what? _____ What type? _____

4. As a baby/toddler, (birth to 4 years), did any of the following occur?

- | | |
|--|---|
| <input type="checkbox"/> Fall from a change table | <input type="checkbox"/> Frequent crying spells |
| <input type="checkbox"/> Tumble down the stairs | <input type="checkbox"/> Frequent fevers |
| <input type="checkbox"/> Fall out of crib | <input type="checkbox"/> Frequent bouts of diarrhea |
| <input type="checkbox"/> Involved in a car accident | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Play in a Jolly Jumper | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Did not gain weight |
| <input type="checkbox"/> Reaction to vaccination | <input type="checkbox"/> Other |

Please explain the above: _____

5. As a young child, (5 to 12 years), did any of the following occur?

- | | |
|--|--|
| <input type="checkbox"/> Fall from a tree | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Fall from a bicycle | <input type="checkbox"/> Hyperactivity/Autism |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Learning difficulties |
| <input type="checkbox"/> Involved in a car accident | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Sports accident | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Stomach pains | <input type="checkbox"/> Leg/knee pains |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Other |

Please explain the above: _____

6. As a child or adolescent, has your child experienced any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness in arm/hands | <input type="checkbox"/> Foot/ankle/knee pains |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> arm/wrist pains | <input type="checkbox"/> Tingling in arm/legs |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck/back pains |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> shoulder pains |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Growing pains |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Other |

Please explain the above: _____

7. Which of the problems you have checked off is the worst? _____

Is this problem: Constant __, Intermittent __, Occasional __, Cyclic ____

8. How long has it persisted? _____

9. When it is at its worst, how does it make your child feel? _____

10. What have you done about it that has NOT worked? _____

11. What makes it worse? _____

12. What effect does this problem have of your child's body functions?

On his/her participation in daily activities? _____

13. Describe any hospital stays: _____

14. Approximately how many times have antibiotics been prescribed and for what conditions? _____

15. List any medications your child is currently taking: _____

16. To summarize, what is your purpose for this appointment? _____

17. Is there anything else you feel we should know? _____

Signature of parent or guardian: _____

Date: _____

FAMILY HEALTH HISTORY

Patient Name: _____ Date: _____

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Siblings		Children		
	Age	Age	Age	Age	Age	Age	Age	Age
ADHD								
Allergies								
Arthritis								
Asthma								
Autism								
Back Trouble								
Bed Wetting								
Bursitis								
Cancer								
Chest Pain								
Colic								
Constipation								
Crohn Disease								
Depression								
Diabetes								
Diarrhea								
Disc Problems								
Down Syndrome								
Ear Infection								
Emotion Issues								
Emphysema								
Epilepsy								
Headaches								
Migraines								
Heartburn								
Heart Trouble								
High Blood Press								
IBS								
Indigestion								
Infertility								
Insomnia								
Kidney Trouble								
Neck Pain								
Neuritis								
Nervousness								
Pinched Nerve								
Scoliosis								
Sinus Trouble								
Other								

Additional Comments:

Thank you!



Pickering Chiropractic and Health Centre

Our purpose at the Pickering Chiropractic Health Centre is to support and Empower you in achieving your optimum health.

Chiropractors locate, analyze and correct subluxations (spinal misalignments, which cause nerve interference). Chiropractic improves the nerve supply of your body to restore, maintain and promote health. Chiropractic treatment, including spinal adjustments, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective for many neck and back conditions involving pain, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than many medical or other treatments, medications and procedures given for the same symptoms.

Informed Consent to Chiropractic Treatment and Payment

Doctors of chiropractic are required to advise patients that there are or may be some remote risks associated with such treatment. In particular you should note: while rare, some patients may experience a short term aggravation of symptoms, rib fracture, muscle and ligament strains or sprains, strokes and disc injuries.

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

I consent to the chiropractic treatment offered or recommended to me by my chiropractor, including, spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

I understand that it is fully my responsibility to pay Pickering Chiropractic for my care at the time of treatment and to confirm with my insurance provider (if applicable) as to coverage for chiropractic care, x-rays, acupuncture and orthotics. *(Appropriate receipts will be provided for me to submit, however, Pickering Chiropractic is not responsible if I am denied coverage.)*

Dated this _____ day of _____, 20_____.

Parent Signature (Legal Guardian)

Witness of Signature

Patient Name (Please Print)

Witness Name (Please Print)

Female Patients – Please Complete

All women of childbearing age must sign this release. *“This is to certify that to the best of my knowledge I am not pregnant and that the Pickering Chiropractic Health Centre has my permission to take x-rays, if required. I will assume all responsibility should I be pregnant.”*

First day of last menstrual cycle: _____
Date

Patient’s Signature