

Dr. Spooner & Dr. McManus

Chart#: \_\_\_\_\_

**NEW PATIENT – CHILD INTAKE FORM**

Name: \_\_\_\_\_ Date of Birth: (M/D/Y) \_\_\_\_\_ Age: \_\_\_\_\_

Sex: \_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ PHN (Care Card#): \_\_\_\_\_

Parent/Guardian Name(S): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Primary # Home \_\_ Cell \_\_

Email Address: \_\_\_\_\_

Preferred communication (i.e. appt. reminders) Email: \_\_\_\_ Text: \_\_\_\_ Cell Provider: \_\_\_\_\_

Who referred you to the office? \_\_\_\_\_

**Purpose for contacting us:** \_\_\_\_\_

Date Problem Began: \_\_\_\_\_

Others seen for this Problem: \_\_\_\_\_

Name of Pediatrician/GP: \_\_\_\_\_

**Delivery History:**

Location of Birth:  Hospital  Birthing Center  Home

Birth Intervention:  Forceps  Vacuum Extraction  Cesarean Section

Complications during delivery? NO\_\_ YES\_\_ List: \_\_\_\_\_

Genetic Disorders or disabilities? NO\_\_ YES\_\_ List: \_\_\_\_\_

Food allergies or Intolerances: NO\_\_ YES\_\_ List: \_\_\_\_\_

**Check any of the following conditions your child has suffered from?**

Ear Infection  Scoliosis  Seizure  Chronic Colds  Headaches

Asthma/Allergies  Digestive Problems  ADHD  Growing/Back Pains

Colic  Bed Wetting  Temper Tantrums

Other \_\_\_\_\_

Vaccination History: \_\_\_\_\_

**Sleep Pattern Normal: NO \_\_\_\_ YES \_\_\_\_ Bowel Movements Normal: NO \_\_\_\_ YES \_\_\_\_**

Is/Has your child had any major falls/injuries/accidents? NO \_\_\_\_ YES \_\_\_\_ Explain: \_\_\_\_\_

Has your child ever been involved in a car accident? NO\_\_ YES\_\_ List: \_\_\_\_\_



# CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

## 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 the 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 or 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 stroke 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 health 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.**

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	

### **OFFICE CANCELLATION POLICY:**

**Please note** there’s a **full charge fee** for missed appointments or for those rescheduled/cancelled with less than 24 hours’ notice. Please remember, with less than 24 hours’ notice, it’s difficult for others to come and fill your vacant appointment time.

**X**

\_\_\_\_\_  
Patient Signature acknowledging they have read and agreed to the above cancellation policy