**Advanced Therapeutic Wellness**
Dr. Nam Nguyen D.C.
1398 Queen St. E.
Toronto, Ont. M4L 1C9
416-469-3879

# CHIROPRACTIC PEDIATRIC INTAKE FORM (0-12)

## *Patient Information*

Date: _____ Child's Name: (last)_____ (first) _____
Parent 1 Name: _____Parent 2 Name: _____
Address: _____ Postal Code_____
Phone:(1)_____(2)_____
Email_____
Child's Age: _____ Weight: _____ Height: _____
Birth date: _____ Birth Place: _____
School/daycare: _____ Family MD/Pediatrician: _____
Referred by:

## *Current Health Condition*

Purpose of appointment/current complaint:

When/how did the current complaint occur: _____
Is this complaint: (circle): new/recurring
Did it come on (circle): suddenly/gradually/comes & goes
Did a fall, injury or trauma contribute to the current complaint: _____
Is your child presently taking medication/or under any other medical care: _____
For what conditions: _____

## *Past Health History*

**Birth History:**

Length of Pregnancy: full term (weeks)_____ / early (weeks): _____/late (weeks): _____
Any issues during pregnancy for mom/baby: (position of baby, blood pressure etc.)

Type of delivery: (circle) Normal vaginal/ Breech/ Cesarean Invasive procedures:
Epidural/ Forceps/ Vacuum

Length of labour: _____ Normal/difficult
Birth Weight: _____ Birth Length: _____ Congenital anomalies: _____

**Advanced Therapeutic Wellness**
Dr. Nam Nguyen D.C.
1398 Queen St. E.
Toronto, Ont. M4L 1C9
416-469-3879

## *Infant History*

Latching well: Y/N Breast preference: Y/N/right/left
Feeding: (circle) Breast/Bottle/Formula
Sleep Quality: good/fair/poor Average hours/night _____Average hours in a row: _____
Trouble falling asleep: (circle) always/occasional/never

## *General Health History*

Any known Health conditions/Allergies:_____
Illness/Injuries: _____
Hospitalizations/Surgeries/ Stitches/ X-rays_____
Previous Massage/ Cranio-sacral Treatment: _____
Date: _____
Last doctor's appointment: _____Concerns: _____
Treatment for any health conditions in the past year:
_____

## *Lifestyle: please circle any that apply to your child*

Activities: Basketball/ Dance/ Running/ Gymnastics/ Skiing/ Swimming/ Hockey/ Soccer
Other: _____
Computer/desk time: _____hours/day
Diet: (circle) Good/fair/poor
Sleep Quality: (circle) Good/fair/poor

**Advanced Therapeutic Wellness**
Dr. Nam Nguyen D.C.
1398 Queen St. E.
Toronto, Ont. M4L 1C9
416-469-3879

Please check any of the following conditions that are currently a problem; and underline any that were a problem in the past:

## MUSCLE & JOINT

| | |
|---|---|
| sore muscles | spinal curvature |
| sore joints | arthritis |
| growing pains | difficulty chewing |
| muscle cramps | clicking in jaw |
| muscle jerking | general stiffness |
| back problems | walking problems |
| neck problems | coordination problems |
| painful tailbone | headaches |
| pain between shoulders | pain in ankles/knees/hips |

## GENERAL

| | |
|---|---|
| Fatigue | dizziness/fainting |
| allergies | earaches/infections |
| difficulty sleeping | nose bleeds |
| sore throat/ frequent colds/flu | asthma |
| chronic cough | enlarged glands |
| loss of weight | nervousness |
| poor exercise/appetite | depression/confusion |
| Vision/dental/hearing problems | hyperactivity |
| behavioural problems | Epilepsy/seizures |
| rheumatic fever | stomach aches |

## INFANCY

| | | |
|---|---|---|
| Colic | Screaming/crying | Fussing in specific position |
| Tilting head to one side | Slow weight gain | |
| Difficulty nursing | Fussing in specific position | |

## ORGANS

| | | |
|---|---|---|
| bedwetting | constipation/diarrhea | anemia |
| Thyroid issues | vomiting | skin eruptions/eczema |

## OTHER CONCERNS

_____

**Advanced Therapeutic Wellness**
Dr. Nam Nguyen D.C.
1398 Queen St. E.
Toronto, Ont. M4L 1C9
416-469-3879

**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. a) 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. b) 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 maybe 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. c) 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. d) 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_____**

**Signature (Legal Guardian) _____Name:_____**