Anderson Chiropractic Group

300 Lakeshore Drive, Suite 102, Barrie, Ontario, L4N 0B4 (705) 734-9520

Child's Health History Form

Child's Name _____ Date_____ File# _____

Parent(s) Name_____

Siblings Names (Ages)_____

Address_____

City: _____ Postal Code_____

Phone: (H)_____ (W): _____ (C): _____

Date of Birth_____ Age_____ Referred by _____

Has your child ever received chiropractic care? ***Yes*** ***No***

If yes, previous DC's name and last visit date?_____

Name of Medical Doctor _____

Date of last MD visit and reason _____

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

PARENT(S) NAMES _____ WORK TEL _____

I hereby authorize and consent to the chiropractic evaluation of my child.

PARENT/GUARDIAN SIGNATURE_____DATE_____

WITNESS SIGNATURE_____

PRESENT HEALTH COMPLAINTS/CONCERNS:

Major_____

Minor_____

When did this problem begin?_____

Is this problem (circle) ***occasional*** ***frequent*** ***constant*** ***intermittent***

Does problem radiate? ***Yes*** ***No*** If Yes, where? _____

What makes this worse?_____

What makes this better?_____

Is the problem worse during a certain time of the day? ***Yes*** ***No***

If Yes, when?_____

Does this interfere with the child's sleep? ____ Eating? ____ Daily routine?____

Is this becoming worse? _____

Other professionals seen for this condition? _____

Results with that treatment? _____

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OTHER HEALTH CONCERNS

□ Allergies □ Asthma □ Bloating/Gas □ Breathing problems
□Chest pain/pressure □Colds/Flu □ Constipation □ Dental problems

□ Depression □Diarrhea □ Dizziness □ Ears buzzing
□ Ears ringing □ Ear pain/infection □ Fainting □ Fatigue
□ Fever □ Flushed face □ Headaches □ Heartburn
□ Heart problems □ Irritability □ Light sensitivity □ Low back pain
□ Mid back pain □ Muscle cramps □ Neck pain □ Numb feet
□ Numb hands □ Numb legs □ Pneumonia □ Reduced mobility
□ Radiating pain □ Sinus congestion □ Sleeping problems □ Sore throat/infection
□ Stiffness □ Upper back pain □ Urinary problems □ Vision changes
□ Weight gain □ Weight loss □ Weakness
□ Loss of: □balance □concentration □ co-ordination □ memory □ smell □ taste

HISTORY OF BIRTH

What was the child's gestational age at birth? ____ weeks.

Birth weight _____lbs _____oz Birth length _____ inches

Was your child's birth at home or in a hospital? (circle one)

Was the birth considered medical or midwife? (circle one)

What was the duration of the labour and birth? _____ hours

Was child born breech? ***Yes*** ***No***

Were there any complications? ***Yes*** ***No*** If Yes, please explain

_____
_____

Please circle any assitance which was used during the birth

Forceps ***Vacuum extraction*** ***C-section*** ***Episiotomy***

Was labour spontaneous or induced? (circle one)

Were medications or epidurals given to the mother during birth? ***Yes*** ***No***
If yes, what was given

_____

APGAR score: at Birth ___/10 After 5 minutes___/10

GROWTH & DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? Yes No
If no, please explain

_____

At what age did the child: Respond to sound _____ Follow an object _____
Hold up head _____ Vocalize _____
Sit alone _____ Teethe _____
Crawl _____ Walk _____

Do you consider the child's sleeping pattern normal? Yes No
If no, please explain

_____
____

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FAMILY HEALTH HISTORY

Please note any health problems (ie. cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:
Mothers family

_____

Fathers family

_____

Siblings

_____

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

PHYSICAL STRESSORS

Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) ***Yes*** ***No***
Please explain

_____

Any evidence of birth trauma to the infant? (please tick)

__bruising ***__odd shaped head***
__stuck in birth canal ***__fast or excessively long birth***
__respiratory depression ***__cord around neck***

Any falls from couches, beds, change tables, etc? ***Yes*** ***No***
If yes, please explain

_____

Any traumas resulting in bruises, cuts, stitches or fractures? ***Yes*** ***No***
If yes, please explain

_____

Any hospitalizations or surgeries? ***Yes*** ***No***
If yes, please explain

_____

Any sports played?

_____

Is a school backpack used? ***Yes*** ***No*** Is it heavy or light? (circle one)

CHEMICAL STRESSORS

Was this child breast-fed? ***Yes*** ***No*** If yes, how long?

_____

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Formula introduced at what age? _____ Which formula?

_____

Introduction of cow's milk? ***Yes No*** If so, at what age?

_____

Began solid foods at what age? _____ Type of foods?

_____

Food/Juice intolerance? ***Yes No*** Type?

_____

During pregnancy, did the mother smoke? ***Yes No*** How much?

_____

drink? ***Yes No*** How much?

_____

Any illnesses during the pregnancy? ***Yes No***

_____

Any supplements taken during pregnancy? ***Yes No***

_____

Any drugs taken during pregnancy? ***Yes No***

_____

Any ultrasounds? ***Yes No*** How many and reasons for being done?

_____

Any invasive procedures during pregnancy (ie amniocentesis, CVS, etc.)? ***Yes No***
Please explain

_____

Any smokers in the home? ***Yes No***

Vaccinations and age given?

_____

Any negative reactions? ***Yes No***

_____

Any antibiotics given? ***Yes No*** Reason

_____

PSYCHOSOCIAL STRESSORS

Any difficulties with lactation? ***Yes***

No_____

Any problems with bonding? ***Yes*** ***No*** _____

Any behavioural problems? ***Yes*** ***No***

_____

Any night terrors, sleep walking, difficulty sleeping? ***Yes*** ***No***

_____

Age of child when began daycare?

_____

Average number of hours of television per week?

_____

Do you feel that your child's social and emotional development is normal for their age? ***Yes*** ***No***

_____

___

Thank you for completing this form. If there are any other questions or concerns which you have, you may write them in the space below.

Anderson Chiropractic Group Informed Consent

In order for the Doctor of Chiropractic indicated below to make a determination on the suitability of my case for chiropractic care, I acknowledge and understand that I must complete a thorough chiropractic evaluation, which may include a diagnostic radiographic examination if clinically indicated. I do hereby request and consent to the performance of such an evaluation by the Chiropractor indicated below, or any party authorized to do so by that Chiropractor.
I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of Chiropractic adjustments and other procedures. I understand that there are, however, some risks associated with Chiropractic care, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit.

I understand that in rare cases there have been incidents of injury to the vertebral artery during the course of care to the cervical spine by medical doctors, physiotherapist, and chiropractors.

However, the proposed mechanism of this injury is reproduced by a wide variety of trivial neck movements such as coughing sneezing, turning your head to look out the back of a car, or having a shampoo at a hair salon. This injury is of concern because it may lead to stroke. The risk of stroke after a cervical adjustment is estimated to be approximately **1 in 1 million.** To put this in perspective, studies that have assessed the risk from interventions a non-chiropractor commonly uses for the same complaints have found the following:

Risk of paralysis or stroke from surgeries or neck pain	**15,600 per 1 million**
Risk of death from surgery for neck pain	**6,900 per 1 million**
Risk of serious GI event from a NSAID (eg.Aspirin,ibuprofen)	**1,000 per million**
Risk of stroke following a chiropractic adjustment	**1 per 1 million**

To put this further into perspective, these studies estimate the risk of death before the age of 35 due to smoking cigarettes is **1677 per 1 million**, and annual risk for being injured in a car accident is **13,333 per 1 million.**

Another complication that may arise following a spinal adjustment is a rib fracture, muscle strain, or ligament sprain. These complications are extremely remote and the Doctor of Chiropractic is trained to assess your spine and adjust in ways that significantly diminish the risk of this occurring.

I have read and understood the risks inherent in undergoing chiropractic care, although, I do not expect the Doctor to be able to anticipate and explain all of the risks that could possibly occur. I wish to rely on the Doctor to exercise judgment during the course of chiropractic care on that basis. I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the Doctor either before or after I sign this consent, and I understand that my consent can be withdrawn at any time.

ANDERSON CHIROPRACTIC DOCTORS:
DR. TOM RYAN D.C., DR. ANDREA RYAN D.C.

Name: _____ Date:_____

Signature: _____ Witness: _____

Anderson Chiropractic Group Fee Consent

Initial Examination

Adult	$ 99.00
Child/Student	$ 89.00

This fee includes cost of consultation, examination and report. Please allot one hour for this initial visit and thirty minutes for the report of findings

Adjustments

Adult	$ 39.00
Child/student	$ 25.00

Progress Examination & Report $20.00

Comparative Examination & Report $50.00

You are responsible for the fees incurred for each visit at the time the services are rendered. If you have extended health care coverage, please check with your insurance carrier for the

particulars of your coverage. It is the policy of this office for the patient/guardian to be responsible for taking care of their account and we will provide you with an itemized statement of the services rendered. We do not bill insurers directly on your behalf. We are also happy to provide you with itemized receipts for income tax purposes.
All new complaints or injuries are assessed as per a new patient with a history and examination to ensure we have the appropriate information to assist you.

Please sign below to indicate that you have read and understood the Investment Schedule. Should you have any questions, please ask front desk staff for further information.

Signature: _____ Date: _____

E-nate Informed Consent

I provide consent to undergo treatment under the care of Dr. Tom Ryan D.C./ Dr. Andrea Ryan D.C., I understand that I will be asked to provide information about my progress throughout the treatment process, which will be added to my patient file. I am also aware that Dr. Tom Ryan D.C./ Dr. Andrea Ryan D.C. will be adding information regarding my treatment to my patient file with every clinical visit that occurs.

It has been explained to me that the information in my patient file will be accessible by myself on an online patient file, when this feature becomes available. I understand this information will allow me to track my own progress and allow me to have an effective form of communication with my Doctor of Chiropractic. I am aware of the benefits of such a system, as it provides my Doctor of Chiropractic with more concise data with which to best manage my care, and it therefore allows for more effective tracking of my therapeutic process.

Name: _____
Date_____

Signature: _____