GLENBOURNE CHIROPRACTIC
INSPIRE WELLNESS.

CHIROPRACTIC Pediatric Health Questionnaire

Date: _____File#_____

Patient Name: _____

Address: _____

City: _____ Prov: _____ PC: _____

Sex: _____ Date of Birth: _____ Health Card #: _____

Family Physician:_____ Phone:_____

Mother: _____ Home Phone: _____ Work Phone: _____

Mother Address: (☐ Same As Above)_____E-Mail:_____

Father: _____ Home Phone: _____ Work Phone: _____

Father Address: (☐ Same As Above) _____E-Mail:_____

Please describe your main reason for consulting our office today:

_____

_____

Are you here for any of the following? ☐ Auto Accident ☐ Sport Injury ☐ Fall/ Trauma

(Please describe):_____

☐Other:_____

Health History

Pregnancy

Please check any areas that applied to the patient's mother during her pregnancy:

□ Complication	□ Premature Contraction	□ Hospitalization
□ Medication	□ Back Pain	□ Immunization
□ Recreational Drugs	□ Other Pain	□ Carried to Full Term
□ Smoking	□ Excessive Weight Loss	□ Bleeding
□ Alcohol	□ Excessive Weight Gain	□ Physical Trauma
□ Caffeine	□ Toxic Exposure	□ Prenatal Classes
□ Allergic Reactions	□ Mental Trauma	□ Vitamins/Minerals
□ Chiropractic Care	□ Any Diagnosed Illness	□ Prenatal Care

□ Other

Please provide us with details:_____

_____

_____

Labor, Delivery and Birth

Please check any areas that applied to the patient's mother during her delivery:

□ Greater than 12 hours
□ Hospital Birth
□ Medication Usage
□ Vacuum Extraction
□ Cesarean
□ Fetal Monitoring
□ Premature Delivery
□ Other
□ Complication
□ Home Birth
□ Forceps

Please provide us with details: _____

_____

Please check any problems the patient had at birth:

□ Breathing
□ Sleeping
□ Choking
□ Nursing
□ Crying
□ Colic
□ Coloring
□ Jaundice
□ Other

Please provide us with details: _____

_____

Childhood

Please check any problems the patient had during childhood:

□ Falls or Injuries
□ Allergy
□ Digestive problems
□ Convulsion
□ Gait problems
□ Respiratory problems
□ Asthma
□ Hyperactivity
□ Immunization
□ Antibiotic use
□ Ear Infection
□ Bedwetting
□ Hospitalization
□ Extremity or back pain
□ Other

□ Medication (Please specify) _____

Please provide us with details: _____

_____

PRIVACY POLICY:

The information requested will assist us in treating you safely. Privacy of your personal information is an essential part of our efforts to provide you with quality care. All staff members who come in contact with your information are trained in the appropriate uses and protection of it. Please note all information provided will be kept confidentially unless allowed or required by law. Your written permission will be required to release any medical information.

CHIROPRACTIC CARE CONSENT:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures. I will have the opportunity to discuss with the doctor, the nature and purpose of chiropractic adjustments and other proposed procedures. I understand that the results expected are not guaranteed, as every person is unique.

I understand and am informed that, as in all health care, in the practice of chiropractic, there are some very rare risks to treatment, including but not limited to: muscle sprains and strain, disc injury and stroke. I do not expect the doctor to be able to anticipate and explain all the risks and complications; I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based on the facts then known, and is in my best interests.

I have reviewed the above information regarding the privacy policy and chiropractic consent. I will have the opportunity to ask questions about its content, and by signing below, I agree to the terms of the policy, and to the doctor's proposed treatment plan. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____

(**Patient Name**)

_____Date:_____

(**Parent or Guardian signature**)