Pediatric Intake

2950 Dundas St. West
Toronto, ON M6P 1Y8
416-766-6572
info@atlashealth.ca
www.atlashealth.ca

PERSONAL INFORMATION:

Today's Date: (DD/MM/YY):_____

Child's Full Name:_____Birth Date (DD/MM/YY):_____Age:_____

Gender: ☐ M, ☐ F, ☐other ☐; Height: _____Weight:_____

Family Doctor Name: _____Contact #: _____Date of last visit: _____

Parent's/Guardians Name(s):_____Parents Email: _____

Address:_____City/Province:_____Postal Code: _____

Home Phone: _____Cell Phone: _____

Emergency Contact:_____ Relation: _____Contact Phone #:_____

We are a family practice; please tell us about your child's family:

Parents Marital Status: ☐S, ☐ M, ☐ D, ☐ W, ☐ CL, ☐ other # of Siblings, and ages:_____

How did you hear about our office?

☐Walked by, ☐ Internet Search, ☐ Event/Presentation, ☐ Referral:_____

Is your child currently receiving care from any other health professionals? ☐ No ☐Yes

If yes, please name them and their specialty: _____

CURRENT HEALTH CONDITIONS:

What health condition(s) bring your child to be evaluated by the chiropractor?_____

_____

Have you received care for this condition before? ☐ Yes, ☐ No **If Yes, please explain**:_____

_____

When did the condition begin?_____How did it start? ☐Suddenly, ☐Gradually, ☐Post-Injury

Is the condition: ☐Getting worse, ☐ Improving, ☐ Intermittent, ☐ Constant, ☐ Unsure

What makes the condition better?_____What makes the condition worse?_____

What is this affecting most in your child's life (List all that apply)?_____

Has your child seen any other providers for this condition? ☐Yes ☐ No Specify: _____

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HEALTH GOALS: List your top 3 health goals for you child:

1. _____

2. _____

3. _____

What health goal, if you were to accomplish it, would have the greatest impact on your child's life? ☐1, ☐ 2, ☐3

What is your level of commitment to your child's health? (1 – Not Committed, 10 – Very Committed): _____

Explain:_____

CHIROPRACTIC HISTORY:

Has your child seen a chiropractor before? ☐Yes, ☐ No - **If Yes -** How long ago?_____

What would you like your child to gain from chiropractic? ☐Resolve Existing Condition, ☐Overall Wellness, ☐Both

Do you have any health concerns for other family members today? _____

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy:

Any Fertility issues? ☐Yes, ☐ No If yes, please explain: _____

Did mother smoke? ☐Yes, ☐ No If yes, how many per week? _____

Did mother drink? ☐Yes, ☐ No If yes, how many per week? _____

Did mother exercise? ☐Yes, ☐ No If yes, please explain: _____

Was mother ill? ☐Yes, ☐ No If yes, please explain: _____

Any ultrasounds? ☐Yes, ☐ No If yes, please explain: _____

Please explain any notable episodes of mental or physical stress during your pregnancy:

_____

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

_____

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LABOR & DELIVERY HISTORY

Child's birth was: ☐Natural vaginal birth, ☐Scheduled C-Section, ☐ Emergency C-section

At how many weeks was your child born? _____ Birth was at: ☐Home, ☐ Birthing Centre, ☐Hospital, ☐Other

Please check any interventions or complications: ☐Breech, ☐Induction, ☐Pain meds, ☐Epidural, ☐Episiotomy

☐Vacuum extraction, ☐Forceps, ☐Premature delivery, ☐Doctor had to pull/twisted baby, ☐Other:_____

Please describe any other concerns or notable remarks about your child's labor and/or delivery:

_____

Child's birth weight: ____lbs____oz Birth height:_____ APGAR score at birth_____APGAR at 5 min_____

GROWTH AND DEVELOPMENT HISTORY

Is/was your child breastfed? ☐Yes, ☐ No If yes, how long? _____Difficulty with breastfeeding? ☐Yes, ☐ No

Did they ever use formula? ☐Yes, ☐No If yes, at what age? _____ If yes, what type?_____

Did/does your child ever suffer from colic, reflux or constipation as an infant? ☐Yes, ☐ No

If yes, please explain: _____

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ☐Yes, ☐ No

If yes, please explain:_____

At what age did the child: Respond to sound:_____Follow an object:_____Hold their head up:_____

Teethe:_____Sit alone:_____Crawl:_____Walk:_____Begin: cow's milk:_____Solid foods:_____

TRAUMAS: Physical Injury History

Please list your child's hospitalization and surgical history, including the year: _____

_____

Please list any major injuries, falls and/or fractures your child has sustained in their lifetime, including the year:

_____

How many hours per day does your child typically spend watching a TV, computer, tablet or phone?_____

Does your child exercise daily? ☐Yes, ☐ No If yes, for how long:_____

Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)?

If Yes, please list: _____

Have they been in any car accidents? ☐Yes, ☐No If yes, explain: _____

How do they normally sleep? ☐Back, ☐ Side, ☐ Stomach ; Do they wake up: ☐ Refreshed & Rested ☐ Tired

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TOXINS: Chemical and Environmental Exposures

Please rate your child's consumption of each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Water	O	O	O	O	O	**Processed Foods**	O	O	O	O	O
Sugar	O	O	O	O	O	**Artificial Sweeteners**	O	O	O	O	O
Dairy	O	O	O	O	O	**Sugary Drinks**	O	O	O	O	O
Gluten	O	O	O	O	O	**Cigarettes**	O	O	O	O	O

How would you describe your child's diet? ☐Mostly whole, healthy foods ; ☐ Average; ☐ Mostly processed foods

Please list any food intolerances or allergies, and when they began: _____

THOUGHTS: Emotional Stresses & Challenges

Does your child have a positive self-esteem or self-image? ☐Yes, ☐ No

Does your child experience prolonged sadness? ☐Yes, ☐No Explain:_____

Night terrors or difficulty sleeping? ☐Yes, ☐No If yes, please explain: _____

Behavioral, social or emotional issues? ☐Yes, ☐ No If yes, please explain: _____

PAST MEDICAL HISTORY

Does your child have any history of: ☐Cancer, ☐ Stroke, ☐ Diabetes

If yes, please explain: _____

Is your child vaccinated? ☐No, ☐ Yes, on a Delayed schedule, ☐ Yes, on schedule

Has your child ever received any antibiotics? ☐Yes, ☐No

If yes, how many times and list reasons: _____

Please list medications they are currently taking: _____

Please list supplements/vitamins they are currently taking: _____

Please note any significant family medical history: _____

_____

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Has your child ever had any of the following childhood conditions?

☐ Chicken Pox	☐ Whooping Cough	☐ Scarlet Fever	☐ Mumps	☐ Measles
☐ Ear Infections	☐ Tubes in Ears	☐ Chronic Illness	☐ Typhoid	☐ Hepatitis
☐ Diphtheria	☐ Rheumatic Fever			

By signing below, I consent to a patient history and physical examination:

Parent/Legal Guardian Signature: _____

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Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.

REGIONS	FUNCTIONS	SYMPTOMS (PAST / PRESENT)			
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐☐ Colic & Excessive Crying ☐☐ Ear & Sinus Infections ☐☐ Allergies & Congestion ☐☐ Immune Deficiency ☐☐ Headaches & Migraines ☐☐ Vertigo & Dizziness ☐☐ Sore Throat & Strep ☐☐ Swollen Tonsils & Adenoids ☐☐ Vision & Hearing Issues ☐☐ Low Energy & Fatigue ☐☐ Difficulty Sleeping ☐☐ Pain, Numbness & Tingling in Arms to Hands		☐☐ Epilepsy & Seizures ☐☐ Sensory & Spectrum ☐☐ ADD / ADHD ☐☐ Focus & Memory Issues ☐☐ Anxiety & Stress ☐☐ Balance & Coordination ☐☐ Speech Issues ☐☐ TMJ / Jaw Pain ☐☐ Stiff Neck & Shoulders ☐☐ Depression ☐☐ High Blood Pressure ☐☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐☐ Reflux / GERD ☐☐ Chronic Colds & Cough ☐☐ Asthma		☐☐ Bronchitis & Pneumonia ☐☐ Functional Heart Conditions	
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐☐ Gallbladder Pain / Issues ☐☐ Jaundice ☐☐ Fever		☐☐ Indigestion & Heartburn ☐☐ Stomach Pains & Ulcers ☐☐ Blood Sugar Problems	
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐☐ Behavior Issues ☐☐ Hyperactivity ☐☐ Chronic Fatigue ☐☐ Chronic Stress		☐☐ Allergies & Eczema ☐☐ Skin Conditions / Rash ☐☐ Kidney Problems ☐☐ Gas Pain & Bloating	
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐☐ Constipation ☐☐ Chrohn's, Colitis & IBS ☐☐ Diarrhea ☐☐ Bed-wetting ☐☐ Bladder & Urination Issues ☐☐ Cramps & Menstrual Issues ☐☐ Cysts & Endometriosis ☐☐ Infertility ☐☐ Impotency ☐☐ Hemorrhoids		☐☐ Sciatica & Radiating Pain ☐☐ Lumbopelvic / SI Joint Pain ☐☐ Hamstring Tightness ☐☐ Disc Degeneration ☐☐ Leg Weakness & Cramps ☐☐ Poor Circulation & Cold Feet ☐☐ Knee, Ankle & Foot Pain ☐☐ Weak Ankles & Arches ☐☐ Lower Back Pain ☐☐ Gluten & Casein Intolerance	

Patient Name: _____ Date: DD /MM/ YY

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CHIROPRACTIC CHIROPRATIQUE Canada

CONSENT TO CHIRPRACTIC 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 is there is a pre-existing condition, chiropractic treatment, like many 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 bowl or bladder functions or impaired leg or arm function. Surgery may be needed.

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- 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.

Alternatives

Alternatives to chiropractic treatment many include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatments.

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.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

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 the 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

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Photo & Video Waiver Form

I, _____, hereby grant permission to Atlas Chiropractic (AC) to take and use any pictures or videos taken at AC for the sole purpose of illustrating and promoting the activities of AC's Services and Products. Pictures and videos in any and all of its publications and in any and all other media, whether now known or hereafter existing, controlled by AC, can be used in perpetuity, and for advertising, marketing, or other uses by AC. I will make no monetary or other claim against AC for use of pictures and videos, and I hereby release AC from all liability from use of pictures and videos.

I am aware that pictures and videos taken AC are considered the property of AC and may not be sold or reused without express written consent of AC.

AC reserves your right to withdraw consent at any time – simply let us know.

By signing this form I confirm that I have read, understand and agree to be bound by it.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date