

Scott Family Chiropractic  
Pediatric consultation

Health Card # \_\_\_\_\_ Version Code \_\_\_\_\_

Name: \_\_\_\_\_

*(As stated on provincial Health card)*

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

*(Street)*

*(City/Town/Village)*

*(Postal code)*

Home # \_\_\_\_\_ Parent's Work # \_\_\_\_\_ ext. \_\_\_\_\_

Where do you prefer to be contacted: Home \_\_\_\_\_ Work \_\_\_\_\_

Parent's Email: \_\_\_\_\_

*(we do not trade, sell, or share any of our email addresses)*

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

*( day / month / year)*

Emergency Contact Name & Number \_\_\_\_\_

How did you hear about our office? : \_\_\_\_\_

*(Please be specific)*

What is your purpose for bringing your child into our office today? \_\_\_\_\_

What goals would you like to achieve for your child's health? \_\_\_\_\_

What are the reasons for wanting to improve your child's health? \_\_\_\_\_

Rate your level of commitment to helping your child achieve these health goals:

Low \_\_\_\_\_ medium \_\_\_\_\_ high \_\_\_\_\_ very high \_\_\_\_\_

When was your child's last chiropractic visit? \_\_\_\_\_

What was the doctor's name and phone number? \_\_\_\_\_

Describe the care your child received. \_\_\_\_\_

**If your child is not experiencing symptoms and simply requests wellness services, please check here \_\_\_\_\_ and skip this section. If there is a specific health concern, please answer the following questions:**

**Describe the nature of your child's symptoms or health concern:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**When did this problem start?** \_\_\_\_\_

**How did it start?** \_\_\_\_\_

**Please list any surgeries your child has had:** \_\_\_\_\_

Has your child had any broken bones? \_\_\_\_\_ If so describe: \_\_\_\_\_

Has your child ever been rushed to the hospital? \_\_\_\_\_ If so describe: \_\_\_\_\_

Describe any falls, traumas or injuries your child has had: \_\_\_\_\_

**Does your child have difficulties with any of the following:**

sleeping \_\_\_\_\_ breathing problems \_\_\_\_\_ ear infections \_\_\_\_\_ learning \_\_\_\_\_  
concentration \_\_\_\_\_ behaviour \_\_\_\_\_ bed wetting \_\_\_\_\_ allergies \_\_\_\_\_  
recurrent colds/infections \_\_\_\_\_ ADHD \_\_\_\_\_ asthma \_\_\_\_\_ colic \_\_\_\_\_ scoliosis \_\_\_\_\_  
constipation \_\_\_\_\_ seizures \_\_\_\_\_ temper tantrums \_\_\_\_\_ growing pains \_\_\_\_\_ eating \_\_\_\_\_

Where there any complications during the pregnancy or delivery of your child? Is so, describe:

Was the delivery vaginal or caesarean? \_\_\_\_\_

Were any assistive devices used? \_\_\_\_\_ forceps \_\_\_\_\_ vacuum \_\_\_\_\_ other \_\_\_\_\_

Has your child ever had a reaction to a vaccination? \_\_\_\_\_

I have read and agree that all information provided is accurate to the best of my knowledge. I also agree, that once explained to me, I will participate in my child's health care and policies and agreements that go with my child's chiropractic care. I understand and agree that health and accident insurance policies are an arrangement between myself and the carrier. I will be provided all the necessary receipts to be reimbursed. I understand that if I suspend or terminate my child's care all fees are due and payable for services rendered. I hereby consent to a preliminary consultation, examination, scans or other diagnostic testing that will assist the doctor in determining if my child is a chiropractic case. If chiropractic care is prescribed, I also agree to chiropractic adjustments, based on my decision to choose chiropractic care for my child. I understand and agree that as in all health care, there are some slight risks and that my child has been examined in order to determine if my child is at risk and the doctor has explained all aspects of my child's care. I will rely on the doctor's judgment during my child's course of care. I intend this consent to cover the entire course of my child's care in this office.

Patient's Name \_\_\_\_\_

Parent or Legal Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness signature (CHA) \_\_\_\_\_