Scott Family Chiropractic
Pediatric consultation

Name: _____Sex: M/F

(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: _____

(month/day year)

Emergency Contact Name & Number _____

How did you hear about our office? : _____

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? _____Chiropractor's Name _____

What is the name of your medical doctor?_____ Tel. # _____

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 ___ be d 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 cesarean? _____

Were any assisted 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) _____ Date: _____