Pediatric Intake Form

Name _____ Date_____

Address _____

City, Province _____ Postal Code _____

Health Card #_____ Gender : Male Female

Name of Parents/Guardian _____ Home Telephone_____

Parent's Work Phone _____ Email _____ Cell _____

Date Of Birth (d/m/y) _____ Age_____ Height (of child)_____ Weight _____

Emergency Contact _____Phone_____

Relationship to Child _____

How did you hear about this office: Friend ☐ Phone book ☐ Sign ☐ Other : _____

Referred by _____

Prior Chiropractic Care:

Name: _____ Date of last appointment _____

Results: Excellent Good Fair Poor

Medical Doctor:

Name: _____ Telephone _____

Address _____

Did your medical doctor recommend that you seek chiropractic care? Yes No

Is it OK if we communicate with your medical doctor regarding your health condition? Yes No

Have any xrays been taken on your spine? Yes No Date:_____

Hammonds Plains Chiropractic

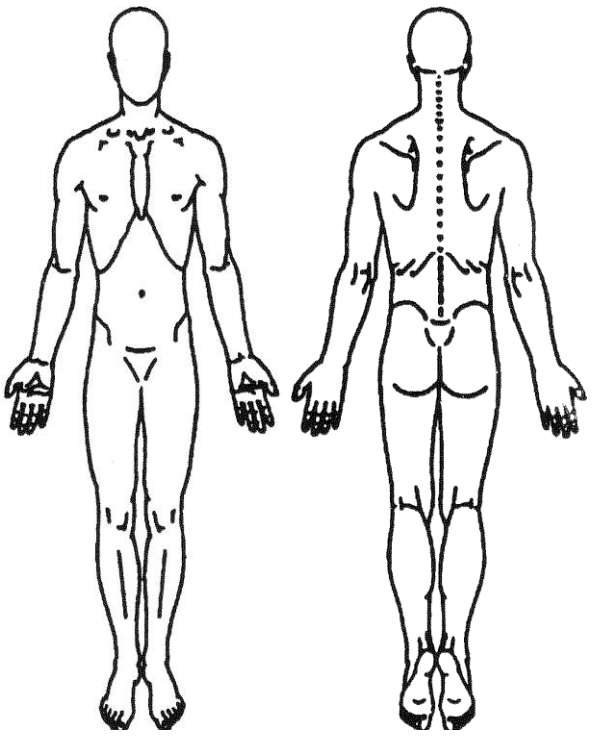
Patient Name: _____ **Date**: _____

Reason for consulting this office: _____

_____

Please indicate on the figures below the areas of your complaint(s) and describe the discomfort using the symbols provided. Please include all affected areas.

Burning X X X X X Aching * * * * * * * Stabbing / / / / / / Pins and Needles 0 0 0 0 Numbness ● ● ● ●



When did this problem begin? _____ How did it occur?_____

Has your child ever experienced this problem in the past? Yes / No If yes, when? _____

What makes this condition worse? _____

What makes it better? _____

Is the problem getting better, worse or staying the same?_____

Have you seen other health professionals regarding this complaint? Yes / No

If yes, whom? _____

Child Health History

Please **check** anything that is currently causing your child problems/concerns.

Please **circle** anything which has been an issue in the past.

- ☐ Ear infections
- ☐ Chronic Colds
- ☐ Sinus troubles
- ☐ Neck pain
- ☐ Back pain
- ☐ Digestive problems
- ☐ Headaches
- ☐ Colic
- ☐ Bed Wetting
- ☐ ADD/ADHD
- ☐ Constipation
- ☐ Diarrhea
- ☐ Scoliosis

Developmental History

Has your child ever been hospitalized? Yes / No If yes, why? _____

Has your child had any previous surgeries? Yes / No If yes, what type? _____

Has your child ever broken any bones? Yes /No If yes, which bone (s)? _____

Has your child ever fallen from any high places? Yes/No If yes, please specify:_____

Has your child ever been involved in a motor vehicle accident? Yes/No If yes, when? _____

What types of injuries were sustained? _____

Prenatal History

Was the delivery vaginal or C-section? _____

Were any of the following used during the delivery: Forceps _____ Vacuum extraction_____
Other:_____

Were there any complications during delivery? Yes/No If yes, please specify: _____

How many weeks at gestation was the baby at birth? _____

Lifestyle

Does your child participate in regular physical activity? Yes / No If yes, how often?_____

Sleep (hours per night): 4-6 6-8 8-10 12+ Is it solid sleep? ☐ Yes / No

What position does your child sleep in? Side / Stomach / Back / All over How many pillows?_____

Rate your child's diet: Poor Fair Good Excellent Meals per day:_____

Does your child take any vitamins or minerals? Yes/ No If yes, please list: _____

Please list any medication(s) taken on a regular basis: _____

Hammonds Plains Chiropractic Fee Schedule and Cancellation Policy

Chiropractic Services

Initial Chiropractic Consultation	$85
Subsequent Chiropractic Treatment	$50
Subsequent Acupuncture (includes chiropractic treatment, if required)	$70
Re-Examination (after 6 months without treatment)	$65

Children and Students and Seniors

Initial Chiropractic Consultation	$70
Subsequent Chiropractic Treatment	$45
Subsequent Acupuncture (includes chiropractic treatment, if required)	$60
Re-Examination (after 6 months without treatment)	$60

Orthotics

Custom Orthotic Inserts	$375

Hours of Operation:

Monday 8:30am – 7pm

Tuesday 2pm – 7pm

Wednesday 8:30am – 1pm

Thursday 8:30am – 7pm

Friday 8:30am – 1pm

- Please note there is a fee for missed appointments and those cancelled with less than 24 hours notice. This is a personal charge that will not be billed to your insurance company. We ask that you please provide a minimum of **24 hours notice** for cancelling an appointment.
- All payments for services are due at the time of the scheduled appointment.
- Those patients whose insurance companies allow for direct billing are required to pay the remaining balance at the time of each visit, if applicable.

I have read, understood and agreed to the above terms and policies.

Patient Name: _____Signature (legal guardian): _____ Date: _____