New Patient Form - Pediatric

Patient Contact Information:

Child's Name: _____ Names of Parents: _____
Date of birth: _____(m/d/y) Age: _____ Sex: □ male □ female
Weight (current): _____ Height (current): _____
Address: _____ City:_____Province: _____Postal code: _____
Phone: Home _____ Cell: _____ Work:_____
Email address:_____
Emergency contact: _____ Relationship:_____ Phone:_____
How did you hear about this office?_____

Prior Medical / Chiropractic Care:

Has your child ever been treated by a chiropractor? □ yes □ no
If yes, name of previous chiropractor: _____ Phone:_____
Date of last chiropractic visit: _____
Family doctor's name: _____ Phone: _____
Date of last physical:_____

Present Health Concerns

Purpose of your child's visit: □ early detection of problems □ prevention □ wellness □ Other:_____
_____
_____
When did this begin? _____

Is the problem worse during a certain time of the day?_____

Does this interfere with your child's sleep? □ yes □ no Feeding?□ yes □ no Daily routine? □ yes □ no

Is it becoming: □ worse □ better □ staying the same

Often, seemingly unrelated symptoms can manifest as other health concerns. Please list any other symptoms you have noticed in your child._____
_____
_____
_____

Birth History

What was your child's gestational age at birth? _____ Weeks

Birth Weight: ____ lbs ____ oz Birth Length: _____ inches

Location of birth: □ hospital □ birthing centre □ home □ other:_____

Was the birth considered: □ medical □ midwife Duration of labour: _____ hrs

Was the child born: □ cephalic (head first) □ breech (feet first)

Were there any complications during pregnancy? □ yes □ no If yes, explain:_____

Were there any complications during delivery? □ yes □ no If yes, explain:_____

Birth Interventions: □ forceps □ vacuum extraction □ cesarean section; if cesarean: □ planned □ emergency
□ episiotomy □ epidural □ medications:_____

Was labour: □ spontaneous □ induced

APGAR score: _____/10 at birth _____/10 after 5 minutes

Growth & Development

Was the infant alert & responsive within 12 hours of birth? □ yes □ no If no, explain:_____

At what age did the child:
respond to sound: _____ follow an object with eyes: _____
hold up head: _____ vocalize: _____
sit alone: _____ teethe: _____
crawl: _____ stand up: _____ walk: _____

Does your child sleep: □ front □ back □ side

Do you consider your child's sleeping pattern normal? □ yes □ no Hours per day: _____
If no, explain:_____

Feeding History

Breastfed: □ yes □ no If yes, how many months: _____

Formula fed: □ yes □ no If yes, how many months:_____

Introduced solids at _____ months, cows milk at _____ months

Food allergies or intolerances? □ yes □ no If yes, list: _____

Family Health History

Please note any health problems (cancers, diabetes, hereditary conditions, heart disease, arthritic conditions, etc.)
Mother's family:_____
Father's family: _____
Siblings: _____

Physical Stresses

Any traumas to mother during pregnancy? □ yes □ no If yes, explain: _____

Any evidence of birth trauma to infant?
□ bruising □ odd shaped head □ cord around neck □ other: _____

Any falls from couches, beds, changing tables etc? □ yes □ no
If yes, explain:

Any traumas resulting in bruising, scratches, cuts, fractures? □ yes □ no
If yes, explain:_____

Any hospitalizations or surgeries? □ yes □ no
If yes, explain:_____

Any sports played? _____

Other

Please list any medications your child has used over the last 6 months:_____

Vaccination history:_____

Does your child have any genetic disorders or disabilities? _____

Please list any childhood sicknesses/infections:_____

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my child's health. I hereby authorize and consent to the chiropractic evaluation of my child.

⇨ Parent/Guardian Signature: _____ Date: _____ (m/d/y)

Fees are due as services are rendered. Supplemental or extended health care insurance may provide coverage for chiropractic services. A receipt will be issued for each payment for this purpose.

I agree and understand that I am responsible for all charges relating to my child's visit.

⇨ Parent/Guardian Signature: _____ Date: _____ (m/d/y)

Privacy Code:
Privacy of personal information is important. Collection, use and disclosure of this information will be in a responsible way. How personal information is handled will be open and transparent.

Personal information is information about an identifiable individual. As part of your child's file, the following will be retained: health history, health measurements and examination results; health conditions, assessment results and diagnoses; the health services provided or received; prognosis and other opinions formed; compliance with treatment; and the reasons for discharge and discharge recommendations. Records will also be maintained for billing purposes. Only necessary information is collected. Information about your child will only be shared with your consent. The use, retention and destruction of personal information complies with existing legislation and privacy protection protocols. Privacy protocols comply with privacy legislation, standards of our regulatory body, the College of Chiropractors of Ontario and the law.

Outlined here is how the clinic uses and discloses this information: to deliver safe and effective patient care, to enable us to contact you, to communicate with other health care providers, to complete and submit claims on your behalf to third party payors, to comply with legal and regulatory requirements under the Chiropractic Act and the Regulated Health Professions Act, to process payments and collect unpaid accounts.

I have reviewed the above information that explains how my child's personal information will be used. I agree that Dr. Miron, can collect, use and disclose my personal information as set out above.

⇨ Parent/Guardian Signature: _____ Date: _____ (m/d/y)

Heath Comes from the Inside Out