ELEVATION CHIROPRACTIC – HEALTHCARE FOR THE ADVENTURER

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Today's Date: ________________________

MB Health # (6 digit)____________________

MB Health # (9 digit)____________________

Child's Name____

Birth Date: Day _____ Month _____Year _____ Age: _____ ☐ Male ☐ Female

Phone Number (Home) ______________Height:_______ Weight:_______ Shoe Size:________

How did you hear about the clinic?

☐Referral: _____________________

☐Internet ☐Radio ☐Live in the area

Address ____ Postal Code __________

City ______________________ Province _______

Mothers Name: ________________________ Mother's Mobile ________________DOB ___ / ___ / ___

Fathers name: ________________________ Father's Mobile ________________DOB ___ / ___ / ___

Pediatrician/Family MD __________________________City/Province ____________________________

Last Visit: ____/____/____ Reason for visit:____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: ☐ Wellness Check-up ☐ Injury or Accident ☐ Other

How was your child delivered? ☐ Vaginal ☐ Forceps/Vacuum Extraction ☐ C-Section

How many round of antibiotics has your child taken in the last year? ________________

HAS YOUR CHILD EVER SUFFERED FROM:

☐ Headaches	☐ Seizures/Convulsions	☐ Sinus Trouble	☐ Fall in baby walker
☐ Orthopedic Problems	☐ Leg Problems	☐ Poor Posture	☐ Fall from bed or couch
☐ Digestive Disorders	☐ Reflux	☐ Hypertension	☐ Fall from crib
☐ Behavioral Problems	☐ Muscle Pain	☐ Asthma	☐ Fall off swing
☐ Dizziness	☐ Heart Trouble	☐ Scoliosis	☐ Fall off bicycle
☐ Neck Problems	☐ Joint Problems	☐ Anemia	☐ Fall from high chair
☐ Poor Appetite	☐ Constipation	☐ Colds/Flu	☐ Fall off slide
☐ ADD/ADHD	☐ Growing Pains	☐ Walking Trouble	☐ Fall down stairs
☐ Fainting	☐ Chronic Earaches	☐ Bed Wetting	☐ Fall from changing table
☐ Arm Problems	☐ Backaches	☐ Colic	☐ Fall off monkey bars
☐ Stomach Aches	☐ Diarrhea	☐ Broken Bones	☐ Fall off skateboard/skates
☐ Ruptures/Hernia	☐ Allergies to__________	☐ Sleeping Problems	☐ Other: ______________________

OFFICE USE ONLY

ID:_______________

Type of Patient:

- ☐ **Wheolse Patient**
- ☐ **Metro Marketing Patient**
- ☐ **MPI Patient**
- ☐ **WCB Patient**
- ☐ **Massage**
- ☐ **Old New Patient**

Last Visit:_________________

- ☐ **Regular New Patient**

Insurance Coverage:________________

- ☐ **Signed INS Forms**
- ☐ **Signed Credit Form**
- ☐ **Free Consultation**
- ☐ **Read Subluxation Pamphlet**
- ☐ **Dr. Ryan**

Notes:

MAJOR HEALTH CONCERNS

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

Problem 1. ____ : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? ___________________ How did the problem(s) begin? ___________________

Is it: ☐ Getting better ☐ Getting worse ☐ Staying the same

How often do you feel the problem? ☐ Daily ☐ Weekly ☐ Monthly ☐ other:____________

How many hours in a day do you feel pain? ☐ 1hour ☐ 4hours ☐ 6hours ☐ 8hours ☐ 12hours ☐ Other:_____________

What makes the pain better? ____

What makes the pain worse? ____

Describe the pain: ____

Is there anything the doctor needs to know about this condition? ____

Problem 2. ____ : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? ___________________ How did the problem(s) begin? ___________________

Is it: ☐ Getting better ☐ Getting worse ☐ Staying the same

How often do you feel the problem? ☐ Daily ☐ Weekly ☐ Monthly ☐ other:____________

How many hours in a day do you feel pain? ☐ 1hour ☐ 4hours ☐ 6hours ☐ 8hours ☐ 12hours ☐ Other:_____________

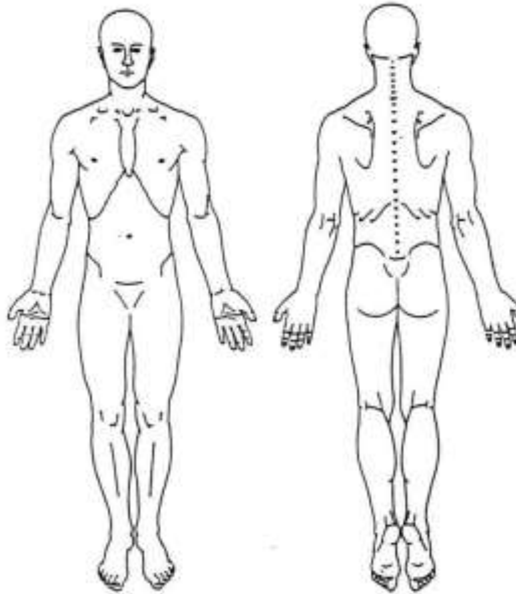
What makes the pain better? ____

What makes the pain worse? ____

Describe the pain: ____

Is there anything the doctor needs to know about this condition? ____

***MARK 'X'** anywhere you feel pain:



PLEASE PROCEED TO THIRD PAGE

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravations of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be cause, by spinal adjustments or other chiropractic treatment;

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my child's condition, and the contents of the Consent.
I consent to the chiropractic treatment recommended to my child by my chiropractor including any recommended spinal adjustments.
I understand at any one time my child's chiropractor may share information from my file with any other chiropractor, massage therapist and/or medical doctor coordinating in my child's care.
I intend this consent to apply to all my child's present and future care with Dr. Ryan Greschuk, DC.

Dated this_____________day of______________________________, 2018

______________________________ Parent/Guardian Signature

______________________________ Witness Signature

Name: ________________________ (please print)

Name: Dr. ________________________ (please print)

____ - I understand that receipts, statements, and notifications will be emailed or texted to me and I consent to receive these electronic communications. (please initial)