HEALTH FOR LIFE
CENTRE

430 Browns Line, Etobicoke, ON, M8W 3T9
Dr. Chrystopher Sly B.Sc, D.C.
(416) 253-5433

Child and Adolescent Health Questionnaire

Name:_____ Birth date:_____

Address:_____
_____

Telephone:_____

Medical Doctor:_____

Parent/ Guardian's Name: _____

How did you hear about us? _____
_____

Section 1 Your pregnancy and child's delivery

1. Did you carry full term?_____

2. Describe any complications and when they occurred:
_____
_____
_____

3. Caesarean-Section? _____
Were forceps used? _____
Was it a difficult delivery? _____
Was the delivery induced? _____
Vacuum extraction? _____
Did you have an epidural? _____

4. Did you consume any alcohol during your pregnancy? _____
How much? _____
Did you smoke during your pregnancy? _____
How much? _____
Did you take any medication during your pregnancy? _____
If yes, what type of medication? _____
How much? _____

Section 2 Your child's daily activities

5. As a baby/ toddler (birth to four years), did any of the following occur?

- Frequent crying spells
- Frequent fevers
- Colic
- Frequent ear infections
- Sleeping problems
- Antibiotic use
- Frequent bouts of diarrhea
- Use of a jolly jumper
- Any falls
- Tonsillitis

6. Please list any childhood illness: _____
_____
_____
_____

7. As a child (5 years to present), have any of the following occurred?

- Asthma
- Bed wetting
- Allergies of Hay fever
- Stomach problems
- Hyperactivity
- Dizziness
- Fatigue
- Any surgery _____
- Ringing in the ears
- Headaches
- Low back pain
- Involved in car accident
- Sports accident
- Any periods of hospitalization
- "Growing Pains"
- Neck Pain
- Numbness or tingling
- Sleeping difficulties

Which of theses problems are the worst? _____
_____
_____
_____

How long has this problem persisted? _____
_____
_____

8. List any medications that the child is currently taking: _____
_____
_____
_____

9. Is there anything else that you feel we should know about? _____
_____
_____
_____
_____

10. What do you hope to gain from this appointment?_____
_____
_____
_____
_____

Examination Fees

	Cost
Consultation	----------Complimentary---------
Examination	$70.00
X-rays (if applicable)	$90.00

I, the undersigned, as parent/ guardian, request and consent to the performance of a chiropractic examination, adjustment and other chiropractic procedures including diagnostic x-rays, if necessary, on _____by the doctor and/ or anyone working in this clinic authorized by the doctor. I assume responsibility for the care and fees for the above mentioned patient for the duration of their care.

_____ _____
Print Child's Name Signature of Parent / Guardian

_____
Date Signed

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"Your Path To Ideal Health"

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back, and other areas of the body caused by nerves, muscles, joints and related issues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.
The risks include:

Temporary worsening of symptoms- Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.

Skin irritation or burn - Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.

Rib fracture- While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.

Injury or aggravation of a disc- Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment , like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

Stroke- Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stoke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present, medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____ Date: _____ 20___
Signature of patient (or legal guardian)

_____ Date: _____ 20___
Signature of Chiropractor

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