PERFORMANCE HEALTH

PEDIATRIC HEALTH HISTORY

ABOUT THE CHILD

PATIENT NAME:	
ADDRESS:	
CITY:	POSTAL CODE:
HOME PHONE:	
DATE OF BIRTH:	AGE:
GENDER:	WEIGHT:

ABOUT THE PARENT

PARENT/LEGAL GUARDIAN NAME:	
ARE YOU THE PARENT OR LEGAL GUARDIAN? ❑ PARENT ❑ GUARDIAN	
MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED	
ADDRESS: ❑ SAME AS ABOVE	
CITY:	POSTAL CODE
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER POSTAL CODE:
WORK PHONE:	POSITION TITLE:

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAS YOUR CHILD EVER SEEN A CHIROPRACTOR? ❑ YES ❑ NO
HAS ANY MEMBER OR YOUR FAMILY EVER SEEN A CHIROPRACTOR? ❑ YES ❑ NO

MEDICATIONS/VACCINATIONS

NUMBER OF DOSES OR PRESCRIPTION MEDICATION CHILD HAS TAKEN DURING HIS/HER LIFE:
PLEASE LIST ALL MEDICATIONS:
HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? ❑ YES ❑ NO
IF YES, CHECK ALL THAT YOUR CHILD HAS RECEIVED: ❑ DPT ❑ MMR ❑CHICKEN POX ❑HEPATITIS ❑ OTHER
DESCRIBE ANY AND ALL REACTIONS TO VACCINE(S):

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT: ❑ WELLNESS ❑ CONDITION IF CONDITION, DESCRIBE:
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: ❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY ❑ OTHER PLEASE EXPLAIN:
WHEN DID THIS CONDITION BEGIN?
HAS THIS CONDITION: ❑ STAYED CONSTANT ❑ GETTING WORSE ❑ COMES AND GOES
DOES THIS CONDITION INTERFERE WITH: ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONDITION OCCURRED BEFORE? ❑ YES ❑ NO PLEASE EXPLAIN:
HAVE YOU SEEN ANOTHER DOCTOR FOR THIS CONDITION? ❑ YES ❑ NO
DOCTOR'S NAME:
TYPE OF TREATMENT(S):
RESULTS:

Performance Health
2528 Dougall Avenue, Windsor Ontario, N8X 1T6 ~ (519) 966-3444

COMPLETE THIS PAGE FOR CHILDREN INFANT TO 5 YEARS OF AGE

PERFORMANCE HEALTH

PRENATAL HISTORY

DURING PREGNANCY DID YOU USE:
❑ DRUGS/MEDICATIONS ❑ TOBACCO/ALCOHOL
IF YES, PLEASE LIST:

LOCATION OF BIRTH:
❑ HOME ❑ BIRTHING CENTER ❑ HOSPITAL

DESCRIBE YOUR DELIVERY:
❑ LABOR WAS INDUCED ❑ C-SECTION DELIVERY
❑ FORCEPTS ❑ VACUUM EXTRACTION
❑ DR PULLED/TWISTED BABY ❑ PREMATURE DELIVERY
❑ EPIDURAL ❑ EPISIOTOMY

PLEASE EXPLAIN:

WAS THE BABY BORN:
❑ CEPHALIC (HEAD FIRST) ❑ BREECH (FEET FIRST)

DESCRIBE ANY COMPLICATION EXPERIENCED DURING DELIVERY:

DID YOU EXPERIENCE ANY ILLNESSES DURING PREGNANCY:
❑ YES ❑ NO
PLEASE EXPLAIN:

BABY'S GESTATIONAL AGE AT BIRTH: ____ WEEKS

BIRTH WEIGHT:	BIRTH LENGTH:
____ lbs ____ oz	____ inches

APGAR SCORE:
At birth ____/10 After 5 minutes ____/10

ULTRASOUND DURING PREGNANCY? ❑ YES ❑ NO NUMBER:

DID YOU BREASTFEED THE BABY?
❑ YES ❑ NO
IF YES, HOW LONG?

DID YOU FORMULA FEED THE BABY?
❑ YES ❑ NO
IF YES, HOW LONG?

AT WHAT AGE DID YOU INTRODUCE:

SOLIDS:

COW'S MILK:

ARE YOU AWARE OF ANY FOOD OR JUICE ALLERIGIES OR INTOLERANCE?
❑ YES ❑ NO
IF YES, PLEASE EXPLAIN:

GROWTH & DEVELOPMENT

HOW MANY HOURS PER DAY DOES HE/SHE SLEEP?

DO YOU CONSIDER THEIR SLEEPING PATTERN NORMAL?
❑ YES ❑ NO

DOES YOUR BABY SLEEP ON THEIR:
❑ FRONT ❑ BACK ❑ SIDE
IF ON THEIR SIDE, DO YOU NOTICE THEM FAVOURING ONE SIDE OVER THE OTHER?

HOW MANY WET DIAPERS DOES HE/SHE HAVE PER DAY?
❑ < 2 ❑ 2-4 ❑ 4-6 ❑ 6-8 ❑ 8-10 ❑ > 10

HOW MANY BOWEL MOVEMENTS PER DAY?
❑ < 1 ❑ 1-2 ❑ 2-4 ❑ 4-6 ❑ 6-8 ❑ >8

AT WHAT AGE DID HE/SHE:

RESPOND TO SOUND	____.	FOLLOW AN OBJECT	____.
HOLD HEAD UP	____	GRASP AN OBJECT	____.
SIT ALONE	____	VOCALIZE	____.
CRAWL	____	TEETHE	____.
WALK	____.		

INSTRUCTIONS: *Please check each of the diseases or conditions that the child now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.*

❑ ACID REFLUX	❑ CONSTIPATION	❑ FREQUENT COLDS, COUGHS, ETC.
❑ ASTHMA	❑ DIARRHEA	❑ HYPERACTIVITY
❑ BED WETTING	❑ DIFFICULT WEIGHT GAIN	❑ LEARNING DISORDERS
❑ COLIC	❑ EAR INFECTIONS	❑ SLEEPING DIFFICULTIES

CURRENT HEALTH STATUS

THE NATIONAL SAFETY COUNCIL REPORTS APPROXIMATELY 50% OF CHILDREN FALL HEAD FIRST FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (I.E. BED, CHANGING TABLE, STAIRS, ETC.?

WAS THIS THE CASE FOR YOUR CHILD? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY?
❑ YES ❑ NO
PLEASE EXPLAIN:

HAS YOU CHILD EVEN BEEN IN A CAR ACCIDENT? ❑ YES ❑ NO
PLEASE EXPLAIN:

DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS?
❑ YES ❑ NO
PLEASE EXPLAIN:

HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES, OR EXHIBITS ROCKING BEHAVIOUR?
❑ YES ❑ NO PLEASE EXPLAIN:

PERFORMANCE 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 no 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 tissues. 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.
- Sprain or strain – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- Rib fracture – While a rib fractures 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 leg or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

PERFORMANCE HEALTH

- 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 stroke. 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, a 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

PERFORMANCE HEALTH

2528 Dougall Ave. Windsor, ON N8X1 T6
Phone: (519) 966-3444
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www.phwindsor.com

Informed Consent to Treatment

Doctors of chiropractic, medical doctors, physiotherapists, acupuncturists and massage therapists may use manual therapy techniques such as spinal and extremity manipulation/mobilizations, soft tissue manipulation, acupuncture, moxibustion, cupping, electroacupuncture, exercises and physical therapy modalities. Health care providers are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal manipulation;

b) There have been reported cases of injury to a vertebral artery following cervical spinal manipulation. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal manipulation is extremely remote;

c) There have been rare reported cases of disc injuries following cervical and lumbar spinal manipulation although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal manipulation.

d) There is a small possibility that as a result of massage and manual muscle therapy the skin may locally be slightly red or sore and even less likely bruised.

I acknowledge I have discussed or have had the opportunity to discuss, with my Treatment Provider the nature and purpose of my treatment in general and my treatment in particular as well as the contents of this consent. I consent to the treatments offered or recommended to me by my Treatment Providers, I intend this consent to apply to all present and future care.

Missed Appointment Policy: Twenty four (24) hours notice is required if you need to cancel your appointment. You may do so via email or by telephone. If it is less than 24 hours before your appointment, you must telephone the clinic. **It is the clinic's policy to charge the patient $25 *for missed appointments without appropriate notice:*** _____ *(patient initials).*

Dated this _____ day of _____, 20____.

_____
Patient Signature

_____
Verification Signature

Name: _____
(Please print)

Name: _____
(Please print)

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ELECTRONIC TRANSMISSION AUTHORIZATION AND CONSENT FORM

Consent to collect and exchange personal information

This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposed of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and/or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and/or plan administrator and their service provider(s) to:

- use my personal information for the above purposes.
- exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposed described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

Print Name	Signature	Date