BURNABY HEIGHTS
INTEGRATED
HEALTH CLINIC

Dr. Ann Izard, B.Comm, DC
Doctor of Chiropractic
405A Beta Avenue Burnaby, BC V5C 5M1
Tel: 604.293.2941 Fax: 604.298.2941

## Chiropractic - Pediatric New Patient Information

Please note that all the information you provide will be kept confidential.

Date: _____

### Patient Information

Child's Name: _____ Sex: _____
Date of Birth: _____ Age: _____
Care Card #: _____

Address: _____ City _____
Postal Code: _____

### Family Information

Mother's Name: _____ Father's Name: _____
Home Phone: _____ Home Phone: _____
Work Phone: _____ Work Phone: _____

Ages of Other Children in Family: _____

### Other HealthCare Providers

Name: _____ Name: _____
Address: _____ Address _____
Phone: _____ Phone: _____

### Reason for Visit

Please list your current health concerns for your child

_____
_____

Is your child currently taking any medications or supplements? If so, please list them:

_____
_____

**Newborn History**

Please complete this section with respect to your child's first 18 months.

Were there any difficulties with pregnancy, labour or delivery? _____
Does (did) your baby go to sleep easily? _____
Does (did) your baby have a preferred sleeping position? _____
Is (was) your baby being breast fed? _____
For how long was your baby breast fed? _____Weeks/months
Does (did) your baby cry a lot? _____
If yes, for many hours each day? _____
Does (did) your baby cry or become irritable during a diaper change?_____
Has (did) your baby had a fever? _____
Has (did) your baby had any falls? _____
Has (did) your baby been in a car accident? _____
Has (did) your baby had any other trauma? _____

**Early Childhood History**

Please also complete this section if your child has reached 18 months of age.

Does your child have any serious or chronic illnesses? _____
Has your child had any accidents or trauma?
Has your child been hospitalized for any reason? _____
Has your child had surgery? _____

Have you noticed any significant changes in your child's
personality and/or behaviour? _____

Please let us know of any concerns that you would like to discuss:

_____
_____
_____

# CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

## Informed Consent to Chiropractic Treatment FORM - L

Doctors of chiropractic who use manual therapy techniques 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 may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

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

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

**Dated this _____ day of _____, 20_____.**

| _____ | _____ |
|---|---|
| **Patient Signature (Legal Guardian)** | **Witness of Signature** |
| **Name:_____** | **Name:_____** |
| **(please print)** | **(please print)** |

CCPA.06.05