Gaia Integrative Clinic
blending science and nature

Chiropractic Pediatric - Information and Consent Form

First Name: _____

Middle Initial: _____

Last Name: _____

Address: _____
Suite/Apt./Unit No: _____
City: _____ Province: _____
Postal Code: _____

Gender: □ Male □ Female Age: _____ Date of Birth: _____
Month / Day / Year

Name of Primary Caregiver: _____
Relationship to Patient: _____
Work Phone:_____ Extension: _____
Home Phone: _____ Mobile Phone: _____
Fax Number:_____ Other Phone: _____
E-mail: _____
Preferred contact method: _____
May we leave a message? _____

Family Doctor or Pediatrician:
Name: _____ Phone Number: _____
Address: _____

Emergency Contact
Name: _____ Phone Number: _____
Relationship: _____

How did you hear about Gaia Integrative Clinic?
□ Referral □ Website □ Newspaper □ Yellow Pages
□ Advertisement □ Friend/Family □ Other:_____

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I, (print your name) _____ , acknowledge that as the parent or guardian of (print child's name) _____,a new patient of this clinic, voluntarily consent to the procedures and treatments provided to me at Gaia Integrative Clinic. I acknowledge and accept that there may be risks associated with these procedures and treatments, and that the risks will be explained to me in a manner that I can understand prior to any treatment. I intend this consent form to cover the entire course of treatment my child receives at Gaia Integrative Clinic. With this knowledge, I understand and acknowledge that I may ask questions regarding my child's treatment at any time and that I am free to withdraw my consent and discontinue participation in any procedures or treatments at any time. I further understand and acknowledge that no guarantees have been given to me by Gaia Integrative Clinic or any of its practitioners or personnel regarding cure or improvement in your child's condition.

I hereby consent to the collection, use and/or disclosure of my child's personal information for purposes related to the delivery of patient care and other related uses at Gaia Integrative Clinic. I understand that a record will be kept of the health services provided to my child. I further understand that my child's personal information including this record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

I hereby acknowledge and agree that I am financially responsible for all payments owing for services received at Gaia Integrative Clinic. I understand and agree that payment must be made at the time services are rendered and/or at the time products are purchased. Additionally, I am aware of the clinic's policy for missed or cancelled appointments. I agree to pay the charge of 50% of the cost of a scheduled visit should I miss or cancel or wish to change a previously scheduled appointment without providing a minimum of 24 hours advance notice.

_____
(parent/guardian's printed name)

_____ _____
(parent/guardian's signature) (date)

PO Box 1401, 4907 47th St, Yellowknife, NT, X1A 2P1•Phone: 867-873-3669• Fax: 867-873-5642
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Chiropractic Pediatric Intake Form

Childs Full Name: _____ Age _____ DOB: _____
Parent # 1 name: _____ Parent # 2 name: _____
Parent #1 Number Hm: _____ wk:_____ cell: _____
Parent #2 Number Hm: _____ wk:_____ cell: _____
Child"s Primary Contact: _____ Alternative: _____
Child's Address: _____ City: _____
Postal Code: _____

Present Health Concerns:
Major: _____
Minor: _____
When did this problem begin: _____
Is this problem □occasional □frequent □constant □intermittent
Does problem radiate? Y N If yes, where _____
What makes this concern worse? _____
What makes this concern better? _____
Is this problem worse at a certain time of day? Y N If yes, when? _____
Does this interfere with the childs sleep? Y N Eating? Y N Daily Routine? Y N
Is this getting worse? Y N

Health History
Purpose of this appointment: Wellness Check-up _____ Other _____
Has this child had previous Chiropractic Care? Y N
If yes, when and for what reason? _____
Other Health Concerns: _____
Have you chosen to vaccinate your child? Y N
If yes, what is your vaccinations schedule? _____
If yes, any reactions following vaccination? _____
Number of Antibiotics doses given to your child in the past 6 months ____ lifetime_____
Other prescription medications/uses: _____
Is your child taking Omega 3 supplements Y N Probiotic supplements Y N
Number of Bowel Movements per day: _____ Hours slept per night: _____

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Prenatal History

Is your child adopted? Y N **If yes**, is your child aware? Y N Age at adoption? _____
Gestational age at birth? _____ Weight? _____ lbs _____ oz Length? _____
Location of birth(please circle): Home Hospital Birthing Centre
Type of Delivery (please circle): Vaginal Forceps Vacuum Extraction
Emergency C section Planned C Section
Was the labour(please circle) spontaneous Induced Length of labour? _____
Who supervised the delivery(please circle) Medical Doctor Midwife
Were medications or epidurals used for delivery? Y N if yes, what? _____
Childs APGAR Score at delivery? _____/10 5 minutes later? _____/10
Ultrasounds during Pregnancy: Y N Number: _____
Weeks of gestation at time of ultrasound(s): _____
Complications during pregnancy: Y N Please Describe: _____
Medications used during pregnancy: Y N _____
Cigarette/Alcohol/Drug use during pregnancy: Y N If Yes, how much: _____
Genetic Disorders or challenges: _____
Was your child breast fed? Y N How Long? _____ Reason for stopping? _____
Was your child formula fed? Y N when? _____ What kind? _____
When were solids introduced? _____ Intolerances? _____
Cow's Milk? _____ Intolerances? _____

Growth and Development
Was your child alert and responsive 12 hours post delivery? Y N
Did your child have problems attaching to the breast? Y N
Did your child have a problem turning their head to breast feed or prefer a breast? Y N
At what age did your child: Respond to sound? _____ Hold their head up? _____
Roll over? _____ Sit alone? _____ Crawl? _____ Walk? _____ Talk? _____

Family Health History
Please note any health problems (ie cancer, diabetes, heart disease, hereditary conditions)
Mothers Family _____
Fathers Family _____
Siblings _____

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Has your child complained of or experienced any of the following?

☐ headaches	☐ chest pressure	☐ weight loss
☐ dizziness	☐ breast pain	☐ weight gain
☐ irritability	☐ frequent colds	☐ dental problems
☐ fatigue	☐ sinus congestion	☐ fevers
☐ depression	☐ sore throats	☐ heart palpitations
☐ loss of balance	☐ ear pain/infections	☐ numbness in feet
☐ loss of concentration	☐ asthma	☐ numbness in hand(s)
☐ fainting	☐ cold sweats	☐ weakness
☐ ears buzzing	☐ bronchitis	☐ heartburn
☐ poor coordination	☐ pneumonia	☐ muscle cramps
☐ vision changes	☐ difficulty breathing	☐ upper back pain
☐ loss of memory	☐ shortness of breath	☐ neck pain
☐ loss of smell	☐ allergies	☐ low back pain
☐ loss of taste	☐ constipation	☐ radiating pain
☐ light sensitivity	☐ diarrhea	☐ sleeping problems
☐ face flushed	☐ urinary problems	☐ numbness in leg(s)
☐ reduced mobility	☐ bloating/gas	☐ colic

Permission to continue: Y N

Authorization for Care of a minor (under 16 yeas old)

Parent(s) (Gaurdian) Name: _____

Work Telephone:_____

I hereby authorize and consent to the chiropractic evaluation of my child

Parent/Gaurdian Signature: _____

Date: _____

Witness: _____

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