



# Welcome

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## Child personal information

First name \_\_\_\_\_ Last name \_\_\_\_\_ M / F  
Birthday (M/D/Y) / / Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs / kgs  
Does your child have any siblings? Y / N  
How many? \_\_\_\_\_ What are their names and ages? \_\_\_\_\_

## Parent's / Guardian's Information

First name \_\_\_\_\_ Last name \_\_\_\_\_  
Address \_\_\_\_\_ Phone number \_\_\_\_\_  
Home \_\_\_\_\_  
Cell \_\_\_\_\_  
City \_\_\_\_\_ Postal code \_\_\_\_\_ Work \_\_\_\_\_  
Email \_\_\_\_\_

May we communicate with you via email (for things like appointment reminders and important information)

YES

NO

Marital status \_\_\_\_\_ Occupation/s \_\_\_\_\_  
Emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
How did you find us? (who can we thank for referring you?) \_\_\_\_\_  
care card number (MSP) \_\_\_\_\_

## We would like to know about your child's history

Has your child been under Chiropractic care before? Y / N If yes when? \_\_\_\_\_

Breast fed Y / N Bottle fed (formula) Y / N \_\_\_\_\_

Does your child drink Cow's milk? Y / N If yes, how much? \_\_\_\_\_

Does your child have any food / juice allergies or intolerances? Y / N If yes, please list \_\_\_\_\_

> OVER

Has your child received any medication/s? Y / N If yes, please list all instances (including dose and duration)

> OVER

Has your child been involved in any high impact or serious falls? Y / N If yes, please list all instances

> OVER

Does your child play contact sports? Y / N If yes, please list \_\_\_\_\_

> OVER

Has your child ever been involved in a car accident Y / N If yes, please describe \_\_\_\_\_

> OVER

Has your child ever been seen in the hospital emergency room? Y / N If yes please describe \_\_\_\_\_

> OVER

Has your child experienced any of the following in the past 6 months?

Ear infections	0	Asthma	0	Seizure	0	Chronic colds	0
Headaches	0	Allergies	0	Digestive problems	0	ADHD	0
Recurring fevers	0	Growing/back pains	0	Colic	0	Bed wetting	0
Scoliosis	0	Temper tantrums	0	Other			

Vaccination history (which vaccinations and when) \_\_\_\_\_

> OVER

Has your child experienced any adverse effects following vaccination/s Y / N If yes, please describe \_\_\_\_\_

> OVER

ADMINISTRATIVE USE ONLY

Doctor has reviewed informed consent with patient

INITIAL

DATE





## Patient Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including X-rays if necessary, on me by the Doctor(s) of Chiropractic affiliated with me. I have had an opportunity to discuss with the doctor(s) of chiropractic, adjustments, and other procedures. Although I am expected to get great benefit from chiropractic care, I understand that the results are not guaranteed. I further understand and am informed that as in all health care, with certain chiropractic techniques, there are some very slight risks to treatment, including, but not limited to, muscle strains, and sprains, disc injuries and rib fractures. The possibility of an associated stroke with an upper cervical adjustment is extremely remote and un-established.

I do not expect the doctor to be able to anticipate all the risks and complications. I rely on the doctor's exercise of judgment which chiropractic procedure, based upon the facts known, is in my best interest. I have read this consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of current and future chiropractic care for which I seek treatment.

I understand that I am responsible for payment of all services and that they are to be paid in full at time service is rendered unless prior arrangements have been made.

### ***Missed Appointment and Cancellation Policy***

***Missed appointments or those who do not inform us of an appointment cancellation 24 hours prior to appointment time will be charged a \$60 fee. There is 24 hour / 7 day a week voicemail, text, and email for your convenience. Thank you.***

Please only read this consent form, to familiarize yourself with it.

**You will sign it once you have had a chance to discuss it with the Doctor.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Doctor to Witness)