Stibbard Chiropractic
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Pediatric Information Form (Birth-12 Years)

Name: ______________________________________ DOB: __________________

Gender: Male Female Other: _________________________

Address: ____

City:______________________________ Province: _______________________

Home Phone: ______________________ Cell Phone: ____________________

Email: ____

Emergency Contact Name: ____

Phone Number: ____________________ Relationship: ___________________

Medical Dr. Name:______________________Date of last physical: _____________

Previous Chiropractor Name: ____

Permission to Contact above health care providers: Yes No

How did you hear about our clinic?: ______________________________________

Private Insurance Provider: ____

Policy #: _____________________ Member #: ___________________________

Name of card holder: ____

Relationship to card holder: ____

Is this a workplace injury or motor vehicle accident?: _______

Claim Number: _________

Patient Information

Parent(s) Name: ________________________

What is the primary reason that you are seeking Chiropractic care for your child?

____

When did this problem begin?________________________________

Is it getting worse? □ Yes □ No

Is this problem:(circle) occasional frequent constant intermittent

Does problem radiate? □ Yes □ No If Yes, where? ____________________________

What makes this worse?___________________________

What makes this better?____________________________

Is the problem worse during a certain time of the day? □ Yes □ No

If Yes, when?____________________________

Does this interfere with the child's sleep?____ eating?____ daily routine?____

Prenatal History

Any complications during pregnancy: ____

During pregnancy, did the mother:

Drink alcohol: □ Yes □ No

Use tobacco: □ Yes □ No

Vaccines/medications □ Yes □ No

Reasons for vaccines/medications: ______________________________

Illnesses/infections during pregnancy: _________________________

Supplements during pregnancy: ______________________________

Ultrasounds or other testing: ________________________________

Birth History

Place of birth: □ Home □ Birthing Center □ Hospital

Provider: □ Midwife □ OB-Gyn □ Other

Type of Birth: □ Vaginal □ Cesarean

Duration of gestation:____

Were pain medications used?____

Was labour induced?____

Birth trauma? □ Doctor Assisted □ Twisting/Pulling □ Vacuum Extraction □ Forceps

APGAR score if known?____

Did your child have a misshaped skull/head? □ Yes □ No

Did your child have any bruising in the skull/face? □ Yes □ No Where? ____________________

Has your baby been diagnosed with any heart issues or other medical concerns? _____________

Please list all medial diagnosis/ concerns: ____________________________________

Did you baby receive a Vitamin K injection at birth? □ Yes □ No

Vitamin K is routinely given to newborns unless you actively refused the treatment

Has your baby previously had a tongue or lip tie release? □ Yes □ No

Have you worked with a lactation consultant outside of the hospital? □ Yes □ No

Growth and Development

Was your infant alert and responsive within twelve hours of delivery? □ Yes □ No

At what age did your child:

Respond to sound: _______Hold up head:_________Begin to teethe: ________Crawl: ________

Follow an object: ________ Vocalize:_________ Sit up unassisted: ________Walk:__________

Has baby had a strong neck since birth? □ Yes □ No

Was baby able to roll to the side in the first weeks of life? □ Yes □ No

Is baby always turning their head to one side? □ Yes □ No L or R (please circle)

Does baby's body seem very tense or rigid □ Yes □ No

Chemical Stressors

Did you breast feed your child? □ Yes □ No How long?______________

Was formula introduced? □ Yes □ No At what age?_________________

Began solids at what age? ______________Type of first food?_________________

List any food allergies?_______________________

Has your child been vaccinated? □ Yes □ No

Did your child have any reactions to these vaccines? □ Yes □ No

Has your child been on antibiotics? □ Yes □ No

If yes, how often and for what purpose?_______________________

Is your child currently taking any vitamins? □ Yes □ No

If yes, please list:_________________________

Please list all medication: _____________________________________

Please list any allergies if known:________________________________

How many glasses does your child drink per day? Water _____Milk _____Juice _____Soda

Does your child consume artificial sweeteners? □ Yes □ No

Rate your child's diet: □ Well-balanced □ Average □ High sugar/processed food

What is your child's favourite food? _________________________

Health History: Please fill out if age 0-4 years

Have any of the following occurred? Please circle

Jaundice	Anemia	Cyanosis	Seizures
Infections	Tonsilitis	Reflux	Repeated colds
Frequent ear infections	Colic	Frequent diarrhea	Constipation
Sleeping problems	Frequent fevers	Frequent crying spells	
Fall from a changing table	Fall out of crib	Fall off playground	Car accident
Tumble down stairs	Play in jolly jumper	Other: ___________________________	

Health History: Please fill out if age 5-12 years

Have any of the following occurred? Please circle

Fall from a tree	Stomach pains	Bed-wetting	
Fall off a bicycle	Hyperactivity/Autism	Headaches/ migraines	
Fall on playground	Leg/Knee pains	Allergies	
Sports accident	Scoliosis	Growing pains	
Car accident	Learning difficulties	Asthma	Other:____________

Does your child participate in any athletic or extracurricular activities? □ Yes □ No

If yes, which ones?____________________________________

How many hours of sleep does your child get per day?________________________

Sleep quality: □ Good □ Fair □ Poor

Is there anything else the Doctor should know? _________________________________

Have you, the child's legal guardian, had any personal experience with Chiropractic? □ Yes □ No

Authorization to Evaluate and Care for a Minor

I, _______________________________, the undersigning parent/guardian having legal custody/guardianship of , a minor, do hereby authorize, request, and direct the staff and doctors of Stibbard Chiropractic Clinic to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Child's Name:___________________________________

Parent/Guardian's Signature: ___________________________Date: ____________________

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 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.

● **Sprainorstrain** –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 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 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, 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.

I hereby acknowledge that I have read this form and 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.

Today's Date:________________________

___________________________________ ______________________________

Patient Name (Please Print) Witness Name

___________________________________ ______________________________

Patient Signature (or Legal Guardian) Witness Signature

Accuracy of Information

I certify that the above medical information is correct to my knowledge. _______________ **Initial Here**

Privacy & Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medial information as documented above. In addition, I authorize the clinic and its associated health professionals communicate with my family doctor and/ or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. _______________ **Initial Here**

Cancellation Policy

Your appointment time is reserved just for youj. A late cancellation of missed visit leaves a hole in the health professionals' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment may be subject to cancellation fee. _______________ **Initial Here**

Direct Billing Consent Forms

Benefit Assignment Form

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/ plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider. ________________________ **Initial Here**

Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

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 purposes 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.

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.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information for the healthcare provider and the insurer and/ or plan administrator and their service provider(s) to use and disclose their personal information as set out above. ________________ **Initial Here**