



South Surrey Chiropractic & Wellness

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CHIROPRACTIC PEDIATRIC INTAKE FORM

Name _____ Date _____

Date of Birth (MM/DD/YYYY) _____ Gender _____

PHN (Care Card) _____

Address _____ City _____

Province _____ Postal Code _____

Home Phone _____ Cell Phone _____

Email _____

How would you like to receive appointment reminders?

Email Text (please indicate your provider: _____)

Would you like to receive our newsletter? Yes No

How did you hear about our clinic? Website Facebook Google Newspaper

Patient (Pt Name: _____) Other: _____

Do you have MSP coverage? Yes No Not Sure

Do you have Extended Health Insurance? Yes No

Extended Health Insurance Company Name: _____

Policy/Plan Number: _____ Member ID/Certificate: _____

Are you the primary coverage holder? Yes No

Primary Holder's name (if different) _____

Primary Holder's DOB (MM/DD/YYYY) _____

PRESENT COMPLAINT _____

Why have you decided to have your child evaluated by a Chiropractor?

- I am continuing ongoing care from another Chiropractor.
- I recently had my spine checked and understand the value of getting my child's spine checked.
- I have concerns about their health and I'm looking for answers.
- They have a specific condition and I've learned that chiropractic may be able to help.
- I want to improve my child's immune function.

Does your child appear to be in pain or discomfort? No Yes

How long has your child been experiencing this?

Is it getting: Better Worse Staying the same

Was the onset: Sudden Gradual

Have you seen any other health professional regarding this complaint? No Yes

If so, whom?

Please list any and all treatments and medications recommended or taken:

CHIROPRACTIC HISTORY ---

Has your child ever been to a chiropractor before? No Yes Date of last visit:

Has a family member previously seen a chiropractor? No Yes if yes, Parent Sibling

Name of Chiropractor:

Reason for seeing them:

Describe your experience:

How frequently did you go for adjustments?

PREGNANCY HISTORY ---

Were any supplements taken during the pregnancy? No Yes (please list)

Were any medications taken during the pregnancy? (prescription or over the counter) No Yes (please list)

Any ultrasounds or other radiation? No Yes

If so, how many and for what reasons?

Were there any invasive procedures during the pregnancy? (amniocentesis, CVS etc.)

No Yes, please explain:

Trauma/illness during pregnancy?

Please describe any emotional stress the mother experienced during the pregnancy:

LABOUR AND BIRTH HISTORY ---

Position during labour On back Side Sitting Standing

Was labour induced? No Yes Reason?

Did the mother have an episiotomy No Yes

Was monitoring used? Internal External

Location of birth? Home Hospital Birthing center

Birth assistants? Midwife Doula Medical doctor Other

Was the mother administered any drugs? Epidural Morphine Other

Was there any intervention use? No Yes Forceps Caesarean Vacuum extraction

How many hours did labour last? Birth Weight: Birth Length:

Was there any evidence of birth trauma to the infant? (check all that apply)

Bruising Stuck in birth canal Respiratory depression

Odd shaped cranium Fast of excessively long birth Cord around neck

Were there any complications during birth or congenital anomalies/defects present?

No Yes Please explain:

MEDICAL HISTORY

Has your child been vaccinated No Yes Partial Alternate schedule Homeopathic

Did you notice any negative reactions?

History of antibiotics? No Yes

Reason?

Has your child taken prescription medications? No Yes

Reason?

Has your child taken over-the-counter medications? No Yes

Reason?

Has your child had any surgeries or hospitalizations? No Yes Reason?

Has your child had any imaging performed? (ultrasound, x-ray, etc.) No Yes

Reason?

GROWTH AND DEVELOPMENT

Was child breast fed? No Yes For how long?

Difficulties with lactation? No Yes

Was formula introduced? No Yes Reason?

Was cow's milk introduced? No Yes At what age?

Have solid foods been introduced? No Yes At what age?

Food intolerances/sensitivities

Quality of sleep Good Fair Poor Average Number of Hours:

Did/does your child favor turning their head to one side while sitting, sleeping or nursing?

No Yes Right Left

At what age did your child start to: Roll Over Crawl Walk

Any complications or delays with motor development?

Any complications or delays with speech development?

Any falls from couches, beds, change tables, etc.? No Yes

HEALTH CONCERNS (please check all that they have experienced in the last 12 months)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Constipation | <input type="checkbox"/> Sensory Processing | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Gas/Flatulence | <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Sleep Difficulty | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Tremors/Shaking |
| <input type="checkbox"/> Autism Spectrum | <input type="checkbox"/> Hip Dysplasia | <input type="checkbox"/> Swollen Tonsils | <input type="checkbox"/> Night Terrors |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Tip Toe Walking | <input type="checkbox"/> Speech Development | <input type="checkbox"/> Seizure(s) |
| <input type="checkbox"/> Balance/Coordination | <input type="checkbox"/> Ear Infections/Aches | <input type="checkbox"/> Torticollis/Head Tilt | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Walking Development | <input type="checkbox"/> Plagiocephaly | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Behavior Issues | <input type="checkbox"/> Feeding Difficulty | <input type="checkbox"/> Pneumonia/Bronchitis | <input type="checkbox"/> Skin Issues |
| <input type="checkbox"/> Food Sensitivities | <input type="checkbox"/> Respiratory Issues | <input type="checkbox"/> Vision/Hearing Loss | <input type="checkbox"/> Epilepsy |

Allergies:

Other:

FEE SCHEDULE

CHIROPRACTIC CARE

	Adult	Senior/Youth
Initial Visit	\$95	\$85
Subsequent Visit	\$60	\$55

DECOMPRESSION THERAPY & COLD LASER THERAPY

	Adult	Senior/Youth
Initial Visit	\$100	\$95
Subsequent Visit	\$70	\$65

SHOCKWAVE THERAPY

	Adult	Senior/Youth
Initial Visit	\$130	\$120
Subsequent Visit	\$100	\$90

CUSTOM ORTHOTICS

	Adult/Senior	Youth
1 Pair	\$480	\$350

ACUPUNCTURE CARE

Initial Visit	\$120 (60 Minutes)
Subsequent Visit	\$100 (45 Minutes)

*Adult: ages 18-64 *Senior: 65+ *Youth: ages 0-17

REGISTERED MASSAGE THERAPY (RMT)

Initial Visit	\$120 (60 Minutes)
Subsequent Visit	\$70 (30 Minutes)
	\$95 (45 Minutes)
	\$115 (60 Minutes)

NON-REGISTERED MASSAGE THERAPY

Initial Visit	\$85 (60 Minutes)
Subsequent Visit	\$55 (30 Minutes)
	\$65 (45 Minutes)
	\$75 (60 Minutes)

ICBC RMT APPOINTMENTS

Please note that ICBC RMT initial visits will be a 60-minute appointment at no cost. Subsequent visits will be 30 minutes also at no cost; however, patients can opt for a 45 or 60 minute subsequent RMT appointment for a small additional fee, as follows:

	\$7.85 (45 Minutes)
	\$27.85 (60 Minutes)

EXTENDED HEALTH BENEFITS

Direct Billing

AVAILABLE HERE!

CANCELLATION POLICY

Out of respect to your practitioner and other patients, 24 hours' notice is required for all cancellations. 100% of the appointment fee will be charged for appointments cancelled without 24 hours' notice. Our cancellation policy will be waived if you are unable to make your appointment due to an emergency or illness.

I understand and agree to the cancellation policy (please initial)

I consent to my file being shared if I decide to see another practitioner at SSCW (please initial)

I understand and agree to the above fee schedule. I understand that this fee schedule is not permanent and may change in the future without notice. Payment is due upon services rendered.

Patient Name (please print) _____

Date _____

Patient Signature (or legal guardian) _____