South Surrey Chiropractic & Wellness
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PEDIATRIC CHIROPRACTIC PATIENT 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/YYY)

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?

PREGANCY 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)

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

□ Allergies:

□ Other:

FEE SCHEDULE

CHIROPRACTIC CARE

	Adult	Senior/Youth
Initial Visit	$100	$90
Subsequent Visit	$65	$60

DECOMPRESSION THERAPY & COLD LASER THERAPY

	Adult	Senior/Youth
Initial Visit	$105	$100
Subsequent Visit	$75	$70

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)

30 Minutes	$80
45 Minutes	$105
60 Minutes	$125
90 Minutes	$180

BODYWORK

30 Minutes	$60
45 Minutes	$70
60 Minutes	$80
90 Minutes	$130

ICBC RMT

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:

45 Minutes	$15.75
60 Minutes	$35.75

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)