

**Chiropractic / Active Release Techniques**

**ADOLESCENT 1 – 17 YEARS OF AGE  
TO BE COMPLETED BY PARENT/GUARDIAN**

Patient's name: \_\_\_\_\_ AHC# \_\_\_\_\_  
Mother's name: \_\_\_\_\_ Father's name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Prov: \_\_\_\_\_ P.C. \_\_\_\_\_  
Home phone \_\_\_\_\_ Mother's work: \_\_\_\_\_ Father's work: \_\_\_\_\_

Patient's birth date: (m/d/yr) \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Purpose of this Appointment: \_\_\_\_\_

Major Complaint: \_\_\_\_\_

Explain How/When Condition Occurred: \_\_\_\_\_

Condition has persisted for: \_\_\_ Days \_\_\_ Weeks \_\_\_ Months \_\_\_ Years

Symptoms: \_\_\_ Came on suddenly \_\_\_ Came on Gradually \_\_\_ Come & Go

What Activites Make Condition Better?: \_\_\_\_\_

What Activites Make Condition Worse?: \_\_\_\_\_

Have you Ever Had This Condition Before?: \_\_\_ No \_\_\_ Yes When: \_\_\_\_\_

Other Doctors Seen For This Condition: \_\_\_\_\_

Describe Other Complaints Involving :

a) Neck/Head: \_\_\_\_\_

b) Mid Back/Shoulder/Arms: \_\_\_\_\_

c) Low Back/Hips/Legs: \_\_\_\_\_

**PAST HEALTH HISTORY**

Medical Doctor's Name: \_\_\_\_\_ Location: \_\_\_\_\_

Last Visit: \_\_\_\_\_ Purpose: \_\_\_\_\_

Previous Chiropractic Care: \_\_\_\_\_

Last Visit: \_\_\_\_\_

X-Rays Taken: \_\_\_\_\_ Where: \_\_\_\_\_ When: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Know Health Conditions: \_\_\_\_\_

Medications: \_\_\_\_\_

**CHILDHOOD DISEASES (please check if applicable)**

\_\_\_ mumps                      \_\_\_ eczema                      \_\_\_ lumbago  
\_\_\_ measles                    \_\_\_ influenza                    \_\_\_ diabetes

<input type="checkbox"/> chicken pox	<input type="checkbox"/> pneumonia	<input type="checkbox"/> asthma
<input type="checkbox"/> small pox	<input type="checkbox"/> tuberculosis	<input type="checkbox"/> anorexia nervosa

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD

<input type="checkbox"/> dizziness	<input type="checkbox"/> colds/flu
<input type="checkbox"/> fainting	<input type="checkbox"/> allergies
<input type="checkbox"/> headaches	<input type="checkbox"/> "growing pains"
<input type="checkbox"/> neck stiff or sore	<input type="checkbox"/> walking problems
<input type="checkbox"/> poor appetite	<input type="checkbox"/> digestive problems
<input type="checkbox"/> sinus congestion	<input type="checkbox"/> ear aches
<input type="checkbox"/> leg pain	<input type="checkbox"/> arm pain

HABITS (please check those activities patient is involved in)

<input type="checkbox"/> hockey	<input type="checkbox"/> skiing	<input type="checkbox"/> swimming
<input type="checkbox"/> gymnastics	<input type="checkbox"/> skating	<input type="checkbox"/> running
<input type="checkbox"/> volleyball	<input type="checkbox"/> biking	<input type="checkbox"/> track & field
<input type="checkbox"/> basketball	<input type="checkbox"/> boating	<input type="checkbox"/> other _____

Quality of Sleep:                     good     fair     poor  
 Does Patient Smoke?:             no         yes     cigarettes per day

FALLS AND ACCIDENTS

Please list all minor and serious falls or injuries this patient has experienced.  
 Keep in mind the above activities, motor vehicle accidents, slips, etc...

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FAMILY HISTORY

	diabetes	cancer	heart	back
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Siblings	_____	_____	_____	_____

**AUTHORIZATION OF CHIROPRACTIC TREATMENT FOR MINORS**

This is to authorize the Doctors of this Clinic and their designate representatives to provide necessary Chiropractic Care including Health History, Consultations, Treatments, X-Rays, and other special Diagnostic Procedures for:

Name: _____	Age: _____
Signed: _____	Relationship: _____
Date: _____	Witness: _____

**CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE**

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- c) There are reported cases of disc injuries following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this consent.

I consent to the chiropractic treatments recommended to me by my chiropractor, including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

**Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.**

\_\_\_\_\_  
**Patient Signature (Legal Guardian)**

\_\_\_\_\_  
**Witness of Signature**

\_\_\_\_\_  
**Name (please print)**

\_\_\_\_\_  
**Name (please print)**

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## Clinic Information

\* Please Read and Sign

### Office Hours

<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>	<u>Friday</u>
9 – 5 pm	8 – 5 pm	9 – 5 pm	8 – 5 pm	8 – 12 pm

### Pricing

PAYMENT IS DUE WHEN SERVICE IS RENDERED. Payment is accepted in the form of cash, cheque, debit card, Mastercard and Visa.

#### Service

<u>Initial Exam</u>	<u>\$ 95.00</u>
<u>Initial Exam Students &amp; Seniors</u>	<u>\$ 80.00</u>
<u>Active Release Techniques</u>	<u>\$ 65.00</u>
<u>Chiropractic Adjustment</u>	<u>\$ 40.00</u>

\*Missed Appointments\* \$20.00 \$20.00

Upon request, our office will be happy to print you statements to submit to your insurance company for reimbursement. WE DO NOT BILL SECONDARY INSURANCE COMPANIES ON YOUR BEHALF, but we will be happy to assist you with your individual insurance forms.

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Signature

Date