South Care Chiropractic

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**PEDIATRIC REGISTRATION AND HISTORY**

**Personal Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parents/Guardians \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prov: \_\_\_\_\_\_\_\_\_\_ Post Code: \_\_\_\_\_\_\_\_\_\_\_

Telephone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about the clinic? Referral Yellow Pages Walk in Sign

If referral, who may we thank for recommending us to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT CONDITION**

Reason for seeking chiropractic care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other doctors/practitioners seen for this condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior treatment and outcome:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other health concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any current or past problems your child has experienced on the list below:

|  |  |  |  |
| --- | --- | --- | --- |
| **GENERAL SYMPTOMS** |  |  |  |
| Dizziness | Allergies | Diarrhea | Broken Bones |
| ADHD | Runny Nose | Poor Appetite | Sprains/Strains |
| Backache | Itchy Eyes | Hyperactivity | Hernias |
| Heart Condition | Rashes | Behavioral | Neck Pain |
| Chronic Earaches | Unusual Moles | Poor Memory | Arm/Elbow Pain |
| Diabetes | Neuritis | Insomnia | Leg/Hip Pain |
| Tuberculosis | Digestive | Nightmares | Knee/Foot Pain |
| Hypertension | Sinus Trouble | Bed Wetting | Growing Pains |
| Fever/Chills | Cough | Pain Urinating | Joint Pain |
| Frequent Colds | Wheeze | Convulsions | Paralysis |
| Scoliosis | Chest Pain | Constipation | Muscle Pain |
| Blood Disorders | Arthritis | Anemia | Fainting |
|  | Headaches | Rheumatic Fever | Other |
|  | Asthma |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Has your child been hospitalized? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications and conditions being treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any car accidents. Sporting injuries, falls etc.:

**PEDIATRIC REGISTRATION AND HISTORY** Name:

**Have any members of your immediate family have any of the following:**

Diabetes **** Heart problems  Kidney problems  Cancer  Back 

**Personal Health Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(please print) authorize the Medical Services Plan to pay SouthCare Chiropractic directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me by said Practitioner. I make this assignment in full knowledge of the amount that I will be personally responsible for and the amount that is reimbursable by the Medical Services Plan, which will be directed to SouthCare Chiropractic to be applied against any outstanding monies I owe for services provided.

This form allows the above named practitioner to receive your MSP reimbursement directly for services that are MSP benefits. Your practitioner, by law, must advise you of his full fee and what portion will reimbursed by MSP. By agreement, your practitioner may not charge you the portion reimbursable by MSP.

Signature of Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date signed:\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMED CONSENT TO CHIROPRACTIC TREATMENT**

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 between chiropractic treatment and the occurrence of stroke rather, recent studies indicate 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 can cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustments is extremely remote;

C) There are rare reported cases of disc injury identified following cervical and lumbar spinal adjustment, although no scientific evidence has been 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 treatment 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(please print) (please print)