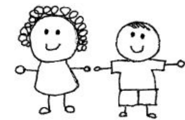
ADAPT CHIROPRACTIC



Pediatric Health Profile

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. Many types of stressors (physical, mental and chemical) can interfere with your child's growing brain, spine and nervous system. To help us serve you better, please complete the following history information about your child. We look forward to working with you to build a better future for your family.

Name: ___________________________________ DOB (mm/dd/year):___________ Age: _____ Male / Female

Address: ______________________________ City: ________________ Province: ____ Postal Code: _________

Height: ______ Weight: _____ Parent / Guardian Name(s): ____

Phone: Home (_____) _____-______ Cell (_____) -_____-_______ Email*: _____________________________

AB Health Care #: _________________ Extended Health Care: Yes / No Provider: ______________________

Who may we thank for referring you? ____

*If provided, email will only be used for reminders, newsletters, event invites, and communication of pertinent office information. You may unsubscribe at any time.

My child is here for:

☐ Wellness ☐ Overall Health Improvement ☐ Specific Health Concern(s): ______________________________

Check any of the following that currently or previously apply:

☐ Abnormal Posture	☐ Back Pain	☐ Colic	☐ Headaches	☐ Temper Tantrums
☐ ADD / ADHD	☐ Bedwetting	☐ Constipation	☐ Language Delay	☐ Torticollis
☐ Allergies	☐ Behavioural Issues	☐ Digestive Problems	☐ Recurring Fevers	☐ Other: ___________
☐ Asthma	☐ Car accident	☐ Ear Infections	☐ Scoliosis	_________________
☐ Autism	☐ Chronic Colds	☐ Growing Pains	☐ Seizures	

How are these concerns affecting your child's quality of life? Please check all that apply:

☐ Attention/Focus	☐ Daily Routine	☐ Playing	☐ Sports
☐ Communication	☐ Eating	☐ School	☐ Walking
☐ Crawling	☐ Exercise	☐ Sleep	☐ Other: ____________

If there is a present health concern, how has it been progressing?

☐ Rapidly Improving	☐ Quickly Worsening	☐ About the Same
☐ Slowly Improving	☐ Gradually Worsening	☐ On and Off

Who else have you seen for the concern(s)? ____

Previous chiropractic care? Yes / No If so, who and when? ____

Name of Pediatrician: ______________________________________ Last Visit: _____________________________

Are you satisfied with the care your child has received at the pediatrician? Yes / No

# of doses of antibiotics your child has taken in the past 6 months: _____ total lifetime: _____

Present prescription drugs/dosage: ____

Previous prescription drugs/dosage: ____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc): ____

Prenatal & Birth History

Name of Obstetrician/Midwife: ____

Complications during pregnancy/delivery? Yes / No Explain: ______________________________________

Ultrasounds during pregnancy? Yes / No If so, How many? ________

Medications taken during pregnancy/delivery: ____

Cigarette / alcohol use during pregnancy? Yes / No

Location of Birth: □ Hospital □ Birthing Center □ Home

Birth Interventions: □ Forceps □ Vacuum Extraction □ Epidural □Episiotomy
□ Induction □ Manual traction of neck □ C-section □ None

If C-Section, was it? □ Emergency □ Planned

Duration of Labour: ____

Genetic Disorders or Disabilities? Yes / No If Yes, Please List: ___________________________________

Birth Weight: ________ Birth Length: ________ APGAR Scores: _____ - _____

Please Check all that apply to your baby's status immediately after birth:

□ Torticollis □ Feeding Problems □ Displaced Joints □ Other: ________________
□ Jaundice □ Respiratory Problems □ Broken Bones

Breastfed? Yes / No How long? _________ Formula Fed? Yes / No How long? _________

Developmental History:
Your child's spine is vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). Spinal nerve interference can affect the following. Check any of the following milestones that your child has/had delays or difficulties meeting:

□ Respond to stimuli □ Hold Head Up □ Cross Crawl □ Walk Alone
□ Respond to visual stimuli □ Sit up □ Stand Alone □ Communication
□ Reaching □ Other(s): ______________ _______________________ _______________________

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. bed, changing table, stairs).
Did your child have a fall similar to that described above? Yes / No Explain: ___________________________

Any other traumas or injuries not described above? ____

Please list any sports your child has been involved in: ____

Hobbies / Interests: ____

Is there anything else you would like us to know about your child? _______________________________________

____

I would like my child to experience the following benefits from chiropractic care:

□ Symptomatic relief □ Correction of the cause of the problem as well as relief □ Prevention of future problems
□ Healthier spine and nervous system □ Optimal health on all levels □ Other: _____________

____ ___________________
Signature of Parent / Legal Guardian Date

Family Health Profile

This form is to assist the doctors by providing family health history information for their review.

Please Mark “P” For In The Past OR Mark “C” For Currently Have:

	Siblings	Mother	Father
Abnormal Posture			
Acid Reflux			
ADHD			
Allergies			
Alzheimer’s			
Anxiety/Nervousness			
Arthritis/Joint Pain			
Asthma/Breathing Difficulties			
Autism Spectrum Disorder			
Autoimmune Disorders			
Back Pain			
Bed Wetting			
Blurred/Double Vision			
Cancer			
Carpal Tunnel			
Depression			
Diabetes			
Digestive/Stomach Problems			
Disc Problems			
Dizziness			
Ear Infections			
Fatigue			
Fibromyalgia			
Frequent Colds/Illness			
Headaches			
Hearing Issues			
Heart Problems			
High/Low Blood Pressure			
Hip/Leg Pain			
Infertility			
Jaw/TMJ Pain			
Kidney Condition			
Menstrual Problems			
Migraines			
Neck Pain			
Numbness/Tingling			
Poor Posture			
Sciatica			
Scoliosis			
Shoulder Pain			
Sinus Issues			
Sleeping Difficulties			
Stiffness			
Stroke			
Thyroid Problems			
Ulcers			

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a digital copy of your x-rays on a **CD for a fee of $10, or via secure encrypted email for no charge**.
Digital x-rays will be available within 72 hours of request on any regular practice hours day. **Please note:** X-rays are utilized in this office to help locate and analyze **vertebral subluxations**. These x-rays are not used to investigate medical pathology, however if any abnormalities are found, we will bring it to your attention and if necessary, refer you to another medical professional for advice.
If your child is an infant or under the age of ten, it is unlikely they will need chiropractic postural x-rays. However, please sign below for future reference.
By signing below you are agreeing to the above terms and conditions.

____ ___________________
Child's Name Child's Age

____ ___________________
Signature of Parent / Legal Guardian Date

Photo and Promotional Release Consent

We love sharing pictures of the healthy and children of Adapt Chiropractic! If you would allow us to take, use, and share your child's photograph and/or testimonial/comments, please sign below. For valuable consideration, I hereby irrevocably consent to and authorize the use for the purposes of marketing and promotion by Adapt Chiropractic, or anyone authorized by Adapt Chiropractic, of any and all photographs/videos which were taken of myself and my child, for the purposes of marketing which may include, but are not limited to promotional materials such as social media, website, and/or print ad whatsoever, for an indefinite period of time without further compensation to me. All media shall constitute the property of Adapt chiropractic, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentiality, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Adapt Chiropractic to share this information via their website and their social media platforms including but not limited to Facebook and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to the Health Information Act).

____ ___________________
Signature of Parent / Legal Guardian Date

Written Consent For A Child/Minor

Name of practice member who is a minor/child: ____

I authorize Dr. Mackenzie Korthuis, Dr. Michael Krotee and any and all Adapt Chiropractic staff, to perform consultation, diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child according to their respective qualifications. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Adapt Chiropractic.

____ ___________________________ ___________________
Signature of Parent / Legal Guardian Relationship Date