

ANDERS VICTORIA FAMILY CHIROPRACTIC

CHILD INTAKE FORM

PERSONAL INFORMATION

				Date:
First Name	Initial	Last Name	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address:	City:	Province:	Postal Code:	AB Health Care #:
Birthday (Month/Day/Year)	Name of Parents/Guardians:		Home Phone Number:	
# of Siblings	How did you hear about us? <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Website <input type="checkbox"/> Facebook <input type="checkbox"/> Referred By:			

MEDICAL AND CHIROPRACTIC INFORMATION

Name of Pediatrician	Last Check-up	City	List Allergies:
What is Your Reason for Seeking Chiropractic Today?			
How Long Have You Been Experiencing This?	Have You Received Previous Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		What Was the Treatment?
Have You Had Previous Chiropractic Care? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, complete the following)</i>	Name of Previous Chiropractor		Last Visit
Reason For Seeking Care:		Results	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

Please check all symptoms that apply:

- | | |
|---|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Poor bowel/bladder control |
| <input type="checkbox"/> Vision changes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Recurrent ear infections |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Arm/Leg pain | <input type="checkbox"/> Other: _____ |

Family History

- Cancer
- Stroke
- Diabetes
- Hypertension
- Autoimmune disease
- Other: _____

Home Environment

- Smoke
- Pets

Activities/Sports

When was your child's last vaccination?

History of antibiotic use:

Infancy History

Delivery method (eg. Caesarian, forceps, induced, any complications): _____

of weeks at delivery: _____ Birth weight: _____

Breastfed? How long? Any difficulties with feeding?

Please list all the **medications and vitamins/supplements** your child is currently taking:

What type of care interests you?

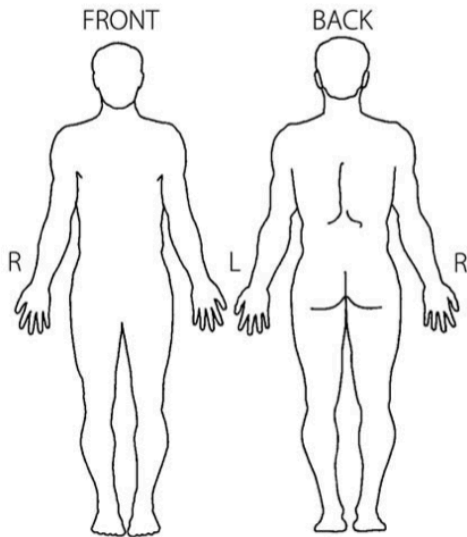
- Pain relief
- Regular Chiropractic and Wellness care to prevent injury, support healthy neurological development, and maintain immune system function so my child can live to his/her full potential

Please Turn Over

Name:

Date:

CHIEF COMPLAINT



HOW TO COMPLETE THIS DIAGRAM

On the body to the left, using the symbols below, please mark the location of your primary complaint and described sensation.

1

Ache XXXX	Burning +++++	Numbness ^ ^ ^ ^ ^ ^	Tingling *****	Stabbing/Sharp ////////	Deep =====
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2

How did your symptoms start?

- sudden
- gradual
- car accident
- work related injury

When did your symptoms start?

- 0-3 months ago
- 3-6 months ago
- 6-9 months ago
- 1 year or more ago

3

Please mark on the line below the level of your discomfort.

0 _____ 10
no pain _____ worst pain

OFFICE POLICY AND FEE SCHEDULE

Welcome to our clinic! We want our office environment to be as positive and constructive as possible, to maximize the healing potential for our patients. Here are a few guidelines and some information to ensure your visits to the office run smoothly.

- Please help us keep our clinic clean by removing wet or muddy footwear when you enter the office.
- When you are given your chart, please proceed to the room number indicated by the receptionist, clip your chart to the outside of the door, and close the door. This is how your doctor will know you are ready for your treatment.

Scheduling

- We encourage all appointments to be scheduled before hand to reduce patient waiting time.
- Drop-ins are welcomed, but scheduled patients will be seen first.
- Cancellation notice** - We value your time and expect that you likewise respect the doctor’s time by making every effort to notify us in the event that you have to miss an appointment. We understand that unforeseen events may make it difficult for you to make your appointment, but we appreciate advanced notice if you need to reschedule your treatment. Repeated violations of this request may result in a charge for the full amount of the missed treatment.

Payment

- Payment is expected in full for each visit. We accept Cash, Cheque, Debit, Visa, Master Card
- Direct Billing is available for Alberta Blue Cross, ASEBP, Great West Life, Sun Life Financial, Green Shield
- Should you discontinue treatment, any outstanding balance will become due immediately and payable in full by you

Fees

Adult Patients

Initial Consultation \$90.00
Adjustments \$45.00

Child Patients

Initial Consultation (Under 18) \$70
Adjustments (13 and older) \$35
Adjustments (0-12) \$30

Other Services

Custom Orthotics \$350
After hours/Emergency - \$55
Supplements – as seen

Current Promotions:

- The last Thursday of every month is Senior’s Day. All patients that are 65 years of age and older can get treated for \$25
- The first week of every month is Family Week. If the whole family attends, everyone will receive treatment for \$25 each

Referrals – Our practice grows through referrals from satisfied patients. We encourage and appreciate when patients are so happy with their treatments that they bring in their friends and family!

With this signature, I declare that I have read and understand the terms and conditions of Anders Victoria Family Chiropractic.

Date: _____

(Print Name)

(Signature of Patient or Parent/Legal Guardian)