ANDERS VICTORIA FAMILY CHIROPRACTIC

Child Intake Form

PERSONAL INFORMATION

Date:

First Name	Initial	Last Name		Gender: ☐Male ☐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? ☐Yellow Pages ☐Website ☐Facebook ☐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? ☐Yes ☐No	What Was the Treatment?	
Have You Had Previous Chiropractic Care? ☐Yes ☐No *(If yes, complete the following)*	Name of Previous Chiropractor	Last Visit	
Reason For Seeking Care:		Results ☐Good ☐Fair ☐Poor	

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

Please check all symptoms that apply:

- ☐ Fatigue
- ☐ Dizziness
- ☐ Poor concentration
- ☐Sleep disturbances
- ☐ Vision changes
- ☐ Headaches
- ☐ Neck pain
- ☐ Back pain
- ☐ Arm/Leg pain
- ☐ Poor appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Poor bowel/bladder control
- ☐ Asthma
- ☐ Frequent colds
- ☐ Recurrent ear infections
- ☐ Allergies
- ☐ Other:_________________

____

Infancy History

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

____

# of weeks at delivery:______ Birth weight:______

Breastfed? How long? Any difficulties with feeding?

____

____

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:

____

____

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

____

____

____

What type of care interests you?

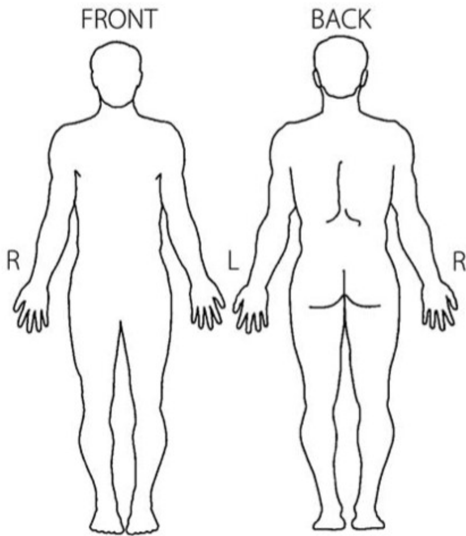
□Pain relief

□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

1

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

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

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 no pain — 10 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		**Child Patients**		**Other Services**
Initial Consultation	$90.00	Initial Consultation (Under 18)	$80	Custom Orthotics $375
Adjustments	$50.00	Adjustments (13 and older)	$40	After hours/Emergency - $60
		Adjustments (0-12)	$35	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 $35
- The first week of every month is Family Week. If the whole family attends, everyone will receive treatment for $40 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)