Gaia Integrative Clinic
blending science and nature

Chiropractic Pediatric - Information and Consent Form

First Name: ____________________

Middle Initial: ____________________

Last Name: ____________________

Address: ____________________
Suite/Apt./Unit No: ____________________
City: ____________________ Province: ____________________
Postal Code: ____________________

Gender: ☐ Male ☐ Female Age: ________ Date of Birth: ____________________
Month / Day / Year

Name of Primary Caregiver: ____________________
Relationship to Patient: ____________________
Work Phone: ____________________ Extension: ____________________
Home Phone: ____________________ Mobile Phone: ____________________
Fax Number: ____________________ Other Phone: ____________________
E-mail: ____________________
Preferred contact method: ____________________
May we leave a message? ____________________

Family Doctor or Pediatrician:
Name: ____________________ Phone Number: ____________________
Address: ____________________

Emergency Contact
Name: ____________________ Phone Number: ____________________
Relationship: ____________________

How did you hear about Gaia Integrative Clinic?
☐ Referral ☐ Website ☐ Newspaper ☐ Yellow Pages
☐ Advertisement ☐ Friend/Family ☐ Other: ____________________

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A division of 506703 NWT Ltd.
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I, (print your name) ____ , acknowledge that as the parent or guardian of (print child's name) __________________________________,a new patient of this clinic, voluntarily consent to the procedures and treatments provided to me at Gaia Integrative Clinic. I acknowledge and accept that there may be risks associated with these procedures and treatments, and that the risks will be explained to me in a manner that I can understand prior to any treatment. I intend this consent form to cover the entire course of treatment my child receives at Gaia Integrative Clinic. With this knowledge, I understand and acknowledge that I may ask questions regarding my child's treatment at any time and that I am free to withdraw my consent and discontinue participation in any procedures or treatments at any time. I further understand and acknowledge that no guarantees have been given to me by Gaia Integrative Clinic or any of its practitioners or personnel regarding cure or improvement in your child's condition.

I hereby consent to the collection, use and/or disclosure of my child's personal information for purposes related to the delivery of patient care and other related uses at Gaia Integrative Clinic. I understand that a record will be kept of the health services provided to my child. I further understand that my child's personal information including this record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

I hereby acknowledge and agree that I am financially responsible for all payments owing for services received at Gaia Integrative Clinic. I understand and agree that payment must be made at the time services are rendered and/or at the time products are purchased. Additionally, I am aware of the clinic's policy for missed or cancelled appointments. I agree to pay the charge of 50% of the cost of a scheduled visit should I miss or cancel or wish to change a previously scheduled appointment without providing a minimum of 24 hours advance notice.

____
(parent/guardian's printed name)

____ ____________________________
(parent/guardian's signature) (date)

Chiropractic Pediatric Intake Form

Childs Full Name: ______________________________ Age ______ DOB: __________
Parent # 1 name: _____________________ Parent # 2 name: _____________________
Parent #1 Number Hm: ______________ wk:_____________ cell: _________________
Parent #2 Number Hm: ______________ wk:_____________ cell: _________________
Child"s Primary Contact: ___________________ Alternative: _____________________
Child's Address: ___________________________ City: __________________________
Postal Code: __________________

Present Health Concerns:
Major: ____
Minor: ____
When did this problem begin: ____
Is this problem □occasional □frequent □constant □intermittent
Does problem radiate? Y N If yes, where _________________________________
What makes this concern worse? ____
What makes this concern better? ____
Is this problem worse at a certain time of day? Y N If yes, when? ________________
Does this interfere with the childs sleep? Y N Eating? Y N Daily Routine? Y N
Is this getting worse? Y N

Health History
Purpose of this appointment: Wellness Check-up _____ Other ___________________
Has this child had previous Chiropractic Care? Y N
If yes, when and for what reason? ____
Other Health Concerns: ____
Have you chosen to vaccinate your child? Y N
If yes, what is your vaccinations schedule? _____________________________________
If yes, any reactions following vaccination? ____________________________________
Number of Antibiotics doses given to your child in the past 6 months ____ lifetime_____
Other prescription medications/uses: ____
Is your child taking Omega 3 supplements Y N Probiotic supplements Y N
Number of Bowel Movements per day: __________ Hours slept per night: ___________

PO Box 1401, 4907 47th St, Yellowknife, NT, X1A 2P1•Phone: 867-873-3669• Fax: 867-873-5642
www.GaiaND.com

Prenatal History

Is your child adopted? Y N **If yes**, is your child aware? Y N Age at adoption? _____
Gestational age at birth? _________ Weight? _____ lbs ______ oz Length? ___________
Location of birth(please circle): Home Hospital Birthing Centre
Type of Delivery (please circle): Vaginal Forceps Vacuum Extraction
Emergency C section Planned C Section
Was the labour(please circle) spontaneous Induced Length of labour? ________
Who supervised the delivery(please circle) Medical Doctor Midwife
Were medications or epidurals used for delivery? Y N if yes, what? ________________
Childs APGAR Score at delivery? _____/10 5 minutes later? ______/10
Ultrasounds during Pregnancy: Y N Number: _____________
Weeks of gestation at time of ultrasound(s): ______________________________________
Complications during pregnancy: Y N Please Describe: ___________________________
Medications used during pregnancy: Y N ______________________________
Cigarette/Alcohol/Drug use during pregnancy: Y N If Yes, how much: _____________
Genetic Disorders or challenges: ____
Was your child breast fed? Y N How Long? _____ Reason for stopping? ____________
Was your child formula fed? Y N when? _______ What kind? _____________________
When were solids introduced? _____________ Intolerances? ________________________
Cow's Milk? _________________________ Intolerances? ____________________________

Growth and Development

Was your child alert and responsive 12 hours post delivery? Y N
Did your child have problems attaching to the breast? Y N
Did your child have a problem turning their head to breast feed or prefer a breast? Y N
At what age did your child: Respond to sound? ______ Hold their head up? _______
Roll over? _______ Sit alone? ________ Crawl? ________ Walk? ______ Talk? ______

Family Health History

Please note any health problems (ie cancer, diabetes, heart disease, hereditary conditions)
Mothers Family ____
Fathers Family ____
Siblings ____

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Has your child complained of or experienced any of the following?

☐ headaches
☐ dizziness
☐ irritability
☐ fatigue
☐ depression
☐ loss of balance
☐ loss of concentration
☐ fainting
☐ ears buzzing
☐ poor coordination
☐ vision changes
☐ loss of memory
☐ loss of smell
☐ loss of taste
☐ light sensitivity
☐ face flushed
☐ reduced mobility
☐ chest pressure
☐ breast pain
☐ frequent colds
☐ sinus congestion
☐ sore throats
☐ ear pain/infections
☐ asthma
☐ cold sweats
☐ bronchitis
☐ pneumonia
☐ difficulty breathing
☐ shortness of breath
☐ allergies
☐ constipation
☐ diarrhea
☐ urinary problems
☐ bloating/gas
☐ weight loss
☐ weight gain
☐ dental problems
☐ fevers
☐ heart palpitations
☐ numbness in feet
☐ numbness in hand(s)
☐ weakness
☐ heartburn
☐ muscle cramps
☐ upper back pain
☐ neck pain
☐ low back pain
☐ radiating pain
☐ sleeping problems
☐ numbness in leg(s)
☐ colic

Permission to continue: Y N

Authorization for Care of a minor (under 16 yeas old)
Parent(s) (Gaurdian) Name: ____
Work Telephone:____
I hereby authorize and consent to the chiropractic evaluation of my child
Parent/Gaurdian Signature: ____
Date: ____
Witness: ____