Welcome to Balanced Health Care!

You will be meeting our chiropractor, Dr. Katherine Tibor, who will be looking at your child's spine and nervous system to determine the cause of his/her condition. Please fill out the information below as this will help Dr. Katherine during the initial visit.

YOUR FIRST VISIT – The Initial Visit:
Dr. Katherine will conduct a thorough health history and physical exam. The physical exam will include checking your child's posture, spinal mobility, and nerve testing. After this, Dr. Katherine may recommend that your child get a set of x-rays taken. This will give her a clearer picture of your child's spine and help her provide your child with the best care possible.

DURING YOUR SECOND VISIT: - The Report of Findings:
Dr. Katherine will go over the results from the first visit. She will provide a diagnosis and present a treatment plan that is best suited for your child's needs. She will then start chiropractic care to get your child's *spine in line*!

Child's name:_____ Today's date:_____

Mother's name:_____ Father's name:_____

Address:_____Postal code:_____

Date of birth (DD/MM/YY) _____ Age: _____ Gender: F M

Home Telephone: (____)_____ Parent's work/cell phone: (____)_____
Can we leave a message here: Y N Can we leave a message here: Y N

Parent's email:_____

Who referred you to us? _____

Family doctor: _____ Family doctor's #:_____
May we contact him/her: Y N

#1 Current Health Concern(s):

What brings your child into our office today?

☐ S/he is continuing care from another chiropractor.

☐ S/he had a spinal check up and we see the benefit of having a well functioning spine.

☐ We are concerned about our child's health and are looking for answers.

☐ My child has a specific condition that we are concerned about:

_____

It began:_____

If this there is pain, please rate it: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain ever)

When does the pain occur? Is it constant? _____

What makes it better? _____ What makes it worse?_____

#2 Physical Stresses:

List all significant *injuries* and *traumas*: _____

List all *hospital visits* and approximate dates: _____

Has your child ever fallen from a height *over 2 feet* or fallen *down the stairs*? Please describe:

_____

#3 Chemical Stresses:

Has your child ever been on antibiotics for an extended period of time? Y N

Is your child ever exposed to second hand smoke on a regular basis? Y N

List any current or previous medication:_____

List any vitamins/supplements:_____

Has your child been vaccinated? If yes, please list the vaccinations and any side effects:

_____

#4 Mental/Emotional Stresses:

Psychological stress has been shown to negatively affect the function of the nervous system. rate your child's overall mental / emotional stress level:

0 (no stress) 1 2 3 4 5 6 7 8 9 10 (extremely stressed)

#5 Nervous System and General Health:

Current or past illnesses/conditions can cause interfere with the function of the nervous system. Does your child have a s*ignificant history* or *recent experiences* of any the following?

Allergies	Chicken pox	Fatigue	Measles/mumps	Seizures
Asthma	Colds	Fevers	Nausea/vomiting	Scoliosis
ADD/ADHD	Colic	Growing pains	Neck pain	Sinus congestion
Back pain	Constipation/Diarrhea	Headaches	Poor posture	Sleep issues
Bed wetting	Digestive problems	Irritability	Rashes/eczema	Other:
Breathing problems	Ear infections	Jaundice	Rubella	_____

Has your child ever had any X-rays / CT scans / MRIs? _____

What are your child's hobbies? _____

Is s/he part of any sports teams? _____

Is there any family health concerns? _____

#6 Prenatal History:

Adopted: Y N Complications during pregnancy?_____

Procedures/specialized tests during pregnancy? _____

Medication(s) during pregnancy? _____

Alcohol/smoking during pregnancy? _____

Location of birth? ☐ Hospital ☐ Home ☐ Birthing Centre

Birth intervention: ☐ Mother induced ☐ Epidural ☐Forceps ☐ Vacuum

Complications during/after birth? _____

#7 Chiropractic Goals:

People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please check which statement best applies to your child:

☐ My child has a specific problem and he or she requires help only with this problem.

☐ After my child's specific problem has been relieved, I am interested in strategies to help ensure it does not return.

☐ After my child's specific problem has been resolved and we have followed advice to help ensure it does not return, I am interested in strategies to improve my child's general health.

☐ My child has no symptoms and feels well. I am interested in strategies to help my child feel and function even better.

I give Dr. Tibor my consent to a complete health history, physical examination, and x-rays, if required, of my child. Unless discussed with Dr. Tibor, payments will be made in full after each chiropractic appointment in accordance with the current fee schedule. I allow for occasional health newsletters from Balanced Health Care to be emailed to me (parent, guardian). These newsletters may include health information, educational/promotional events, and/or any updates pertaining to the clinic. I understand that I am able to unsubscribe from these emails at anytime.

Parent/Guardian's signature: _____ Date: _____