IN LINE FAMILY CHIROPRACTIC

920 Yonge Street PO Box 1030
Walkerton, ON N0G 2V0
519-881-3443
www.ilfc.ca

Child Intake Form

To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Personal Information

Patient Name:________________________ Birth Date:______________ Weight _____lbs
Address:________________________________ Province______ Postal Code:______________
Home Phone: __________________ Parent's Work Number: __________________
Name of Parent / Guardian ____
Email address ____
How did you hear about our office? ☐ Google ☐ yellow pages ☐ newspaper Ad ☐ lecture/program
☐ office website ☐ radio Ad ☐ existing patient; referred by __________________ ☐ other __________________

Reason(s) for visit:____
Other doctors seen for this Condition: yes no Doctor(s) name:________________________
Prior Treatments:____
Other health problems:____
Previous Chiropractic Care?________________________Date of last Visit:______________
Reason:____
Name of medical doctor:________________________ Date of last visit:______________
Reason:____

Prenatal History

Any accidents or fall during the pregnancy?________________________________
Complications during pregnancy? (preeclampsia, excessive weight gain, sugar or other problems) Yes No
List:____
Ultrasounds during pregnancy? Yes No Number:________________________
Medications during pregnancy / delivery? Yes No List:________________________
Cigarette / Alcohol use during pregnancy? Yes No
Complications during delivery? Yes No List:________________________
Genetic disorders or disabilities? ________________________________

Birth:

Length of labour____________
Birth Intervention: ____ forceps ____vacume extraction ____caesarian section, emergency or planned?
Location of birth: ____ hospital ______home ______birthing centre
Any unusual skull shape?____________
Was your child's head, neck, arms or legs being held in any unusual position? ______________________

Feeding History:

Breast fed: Yes No How long?________ Formula fed: Yes No How long?_________
Introduced to solids at:_______months Milk at _______months Type of milk_______________
Food / Juice Allergies or Intolerances: ____

Developmental History:

During the following times your childs spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Crawl: _______________ Sit independently: ______________ Stand: _______________ Walk: ________________
Did your child respond to sound and follow objects well?________________________________
Did your child gain and grow satisfactorily?________________________________

Has your child had any major falls? Yes No
From heights? (ex. off a bed, change table, down stairs?)________________________________
Did they land on their head? Yes No
Is or has your child been involved in any high impact or contact sports? (ex. soccer, football, gymnastics, martial arts, etc.) Yes No Please List:________________________________
Has your child ever been in a car accident? Yes No Details:________________________________
Other Traumas not listed above? ________________________________
Prior Surgery? Yes No Details: ________________________________

Childhood Diseases:

___Chicken Pox ___Mumps ___Rubella ___Whopping Cough ___Rubeola Other______________________

Has this child ever suffered from? Please circle.

Dizziness	Backaches	Heart Trouble	Chronic Ear Earaches
Diabetes	Tuberculosis	Hypertension	Cold/Flues
Arthritis	Headaches	Asthma	Allergies
Neuritis	Digestive Disorders	Sinus Trouble	Constipation
Anemia	Rheumatic Fever	Orthopedic Problems	Diarrhea
Poor Appetite	Hyperactivity	Sugar Concentration	Behavioral Problems
Bed Wetting	Convulsions	Paralysis	Muscle Jerking
Fainting	Walking problems	Broken Bones	Ruptures/Hernia
Neck Problems	Arm Problems	Leg Problems	Joint Problems

Further Comments:________________________________
____
____
____
____

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Office Fee Schedule and Financial Policy

Service	Adult	Child/Student
Consultation	N/C	N/C
Initial Exam	$100	$50
Adjustment	$40	$25
Initial ABC Treatment (New Patient)	$140	$140
Initial ABC Treatment (Existing Patient)	$110	$110
ABC Adjustment	$55	$55
Endonasal Treatment	$55	$55
Dynamic Exam and Spinal Scan	$30	$20
Low Volt Therapy	$2.50/minute	$2.50/minute
Initial Exam Laser/Low Volt Therapy	$50.00	$30.00
Laser Therapy	$45.00/session	$45.00/session
Ion Cleanse	$35.00	$35.00

Orthotics: One Pair - $450.00 Two Pair - $715.00

Massage: One hour initial $85.00 Half Hour Initial $61.00 45 Minute Initial $72.00
One hour $70.00 Half Hour $46.00 45 Minute $57.00

January 1st of each year there will be an annual cost of living increase in the fees rounded to the closest dollar.
There is a $30.00 minimum fee for the reproduction and/or forwarding of a file to another practitioner.

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. **You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange an Active Life Plan in advance.** These Active Life Plans are designed to be the most cost effective way to keep you and your family as healthy as possible. They include your Symptom Care, Corrective Care and Supportive Care options. Details of these plans will be discussed with you during your Report Of Findings.

- **Benefits / Insurance:** If you have insurance that covers chiropractic, we will give you all of the information you need to get reimbursed quickly. This includes your diagnosis, prognosis, and copies of your records or reports. We have found it is easier for your record keeping, and ours, if we give you receipts at the end of your first visit and then once a month after that. Just send in your receipts with a copy of your claim form and your insurance company will communicate with you about your reimbursement. Remember, your agreement with your insurance company is between you and them.

If a special situation arises, such as an auto accident or a worker's compensation injury and you choose to utilize that coverage, a new examination will need to be performed and you will be charged our regular office fees until such claim is settled. We will help you get reimbursed quickly on these claims. Depending on the situation, we may bill the insurance company directly. Once the claim is complete, your active life plan will be re-activated.

I have read and I understand the above policies.

Patient Signature Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ________________________________ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

________________________________ (signature)

________________________ (date)

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Name:______________________________ **Date:**______________________________

INFORMED CONSENT TO CHIROPRACTIC EXAMINATION

There are risks and possible risks associated with chiropractic examinations used by doctors of chiropractic and their staff. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains, sprains as a result of their examination.
b) Patients with skin sensitivity may react adversely to the alcohol swab used to perform the EMG study.

I acknowledge that if I choose not to consent to all and/or part of the examination I will have ample opportunity to discuss with the doctor further options. I also understand that without a thorough examination, no treatment will be provided to me. I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic examination in general, options and recommendations in particular for my condition.

______________________________ ______________________________
Patient Signature or Legal Guardian Witness of Signature

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains, sprains as a result of manual therapy techniques. Although, uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustments, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
d) There are infrequent reported cases of burns or skin irritation in association with the use of some type of electrical therapy offered by some doctors of chiropractic.
e) Because we are a current, up to date office that prides ourselves on working with the latest technique models to help advance patient care, at times some of the techniques that we use in this office may be considered experimental.
f) We are a multi-doctor chiropractic office so at any time you may be adjusted by a different doctor including associates and/or locum doctors. The quality of your care depends on consistency. All of our doctors are trained to detect and adjust subluxation with the highest of quality. They will keep accurate records so that we all are aware of what was done on each visit and proper follow up can be provided.

______________________________ ______________________________
Patient Signature or Legal Guardian Witness of Signature