Westside Family Chiropractic

ROBERT RUDY, B.Sc., D.C.

Kawartha Heights Plaza
7A–1600 Lansdowne St. W.,
Peterborough, ON K9J 7C7

Phone: (705) 741-2225
Fax: (705) 741-0103
www.westsidefamilychiropractic.com

PEDIATRIC PATIENT INTRODUCTION

Child's Name _____ Date _____

Mother's Name _____ Father's Name _____

Address _____ City _____ Postal Code_____

Date of Birth _____ Age_____ Gender _____

Home Phone _____ Mother's Cell #_____ Father's Cell#_____

E-Mail _____ Pediatrician _____

I allow this office to share medical information with the family doctor/Pediatrician. Initial_____ Date_____

Purpose of this Appointment _____

How long has your child suffered with this problem? _____ Is it getting worse? _____

Previous Diagnosis and Treatment _____

How does this problem interfere with the following areas of your child's life?

Family: _____

School: _____

Hobbies/Sports: _____

Has your child had any previous Chiropractic Care? Y / N When _____ Who_____

FAMILY HEALTH PROBLEMS: Many health problems are the result of hereditary spinal weaknesses.
This information about your family members will give us a better picture of your child's total health.
Please list any member of your family who has had any kind of health problem.

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

BIRTH HISTORY

Type of Birth: Normal Vaginal ___ Forceps ___ Breech ___ Cesarean ___

Problems During Pregnancy: _____
_____

Problems During Labour/Delivery: _____
_____

At birth, was there the presence of: Jaundice (Yellow) _____? Cyanosis (Blue) _____?

HEALTH HISTORY

List any Surgeries/Accidents/Falls _____

Is your child on any Medications? (please list) _____

CHECK OFF ANY OF THE FOLLOWING YOUR CHILD HAS EXPERIENCED RECENTLY:

( ) Allergies
( ) Bronchitis
( ) Ear Infections
( ) Headaches/Migraines
( ) Loss of Energy
( ) Poor Coordination
( ) Sinus Problems
( ) Tonsillitis
( ) Bedwetting
( ) Dizziness
( ) Fevers
( ) Hyperactivity
( ) Pneumonia
( ) Poor Appetite
( ) Sore Throats
( ) Other_____
( ) Breathing Difficulties
( ) Digestive Difficulties
( ) Frequent Colds/Flus
( ) "Growing Pains"
( ) Poor Emotional Control
( ) Regular Vaccinations
( ) Stomach Aches

HAS YOUR CHILD EVER:	**YES**	**NO**
Been knocked unconscious	( )	( )
Used a cane, crutch or other support	( )	( )
Been treated for spine or nerve disorder	( )	( )
Had a fractured bone/broken bone	( )	( )
Been Hospitalized	( )	( )

DATE OF LAST:
Spinal Examination
Physical Examination
Blood Test
Chest X-Ray
Spinal X-Ray
Dental X-Ray
Urine Test

AUTHORIZATION FOR CARE OF A MINOR

By signing below, I confirm all legal parents or guardians of the minor child have been advised and agree to allow this clinic and Dr. Rob to administer care.

I hereby authorize this clinic and Dr. Rob to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

Print Name _____ Relation to child _____

Signed_____ Witness_____ Date_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered are charged directly to me and I am personally responsible for payment to this clinic.

Signature_____ Date_____