



2418 Lakeshore Road West  
Oakville, ON L6L 1H7

**Pediatric Chiropractic  
New Patient Form**

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**Patient and Guardian Information (please print clearly)**

Name: \_\_\_\_\_ Date of Birth: mm/dd/yyyy \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Height/length: \_\_\_\_\_ Weight: \_\_\_\_\_ Family doctor: (name) \_\_\_\_\_ (number) \_\_\_\_\_

Name of parents/guardians: \_\_\_\_\_

Primary Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (B) \_\_\_\_\_ (M) \_\_\_\_\_

Email: \_\_\_\_\_

Where did you find our number? \_\_\_\_\_ If online, what site referred you? \_\_\_\_\_

Emergency Contact: (Name) \_\_\_\_\_ (Relationship) \_\_\_\_\_ (Phone number) \_\_\_\_\_

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**Billing Information**

**Is the complaint related to a motor vehicle accident?**  Yes  No

*If Yes, please fill in the following:*

Date of accident: \_\_\_\_\_ Insurer's name: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Insurer's address and telephone number: \_\_\_\_\_

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**Fee Schedule**

Fees are posted at the clinic and online at [www.wellnessforthebody.com](http://www.wellnessforthebody.com). They are subject to change without notice.

Payment is due at the time services are rendered. For your convenience, we accept cash, cheque, debit, Visa and Mastercard. This policy applies to all of our patients. We understand that unusual circumstances may arise and that payment in full at the time of service may not always be possible. Special payment needs should be discussed by the patient and a member of the business department. Payment plans are subject to approval by the administrator and your chiropractor. You will receive a monthly statement showing all charges and payments. If you have not made payment in full, or made full financial arrangements with our office, your account will be reviewed for collection. If payment is not made on a bill from our office within forty-five (45) days after the date of the bill, interest may be charged to you on the balance of such bill commencing on the forty-fifth (45) day after the date of the bill. The interest rate will be eighteen percent (18%) per annum. Patients having health care coverage should remember that professional services provided are the patient's responsibility, not the insurance company. Our office does not file insurance claims for you; however, we would be happy to help you find the necessary documents and invoices upon complete payment of services for you to submit for reimbursement.

We require 24 hours notice if you are unable to make your scheduled appointment. After an initial warning there is a charge of \$20.00 for a second missed appointment. All subsequent missed appointments will then be billed at the regular fee.

Custom-made orthotics will not be ordered for a patient until the patient has paid at least 50% of the item cost. We do realize that custom orthotics are an expensive part of treatment and we do make every attempt to control these costs. Our staff is available to assist patients with insurance benefit verification for such items.

If you have any further questions regarding insurance, be certain to bring in your insurance book so we can determine your coverage and avoid confusion. We want your experience with Wellness for the Body to be a pleasant one and we hope this information will help to make it so.

I have read the Wellness for the Body financial policy and understand my financial responsibility and agree to the terms stated in the Financial Policy. I HEREBY AGREE TO PAY ANY AND ALL CHARGES FOR SERVICES RENDERED AND ITEMS PURCHASED AT WELLNESS FOR THE BODY.

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## Health History

Previous fractures, surgeries, or hospitalizations (Please list and date):

### History of Birth

- Hospital  
 Birthing Center  
 Home  
 Medical  
 Midwife  
 Normal Delivery  
 Assisted Delivery  
     If yes:  Forceps  
            Vacuum extraction  
            C-section  
            Induced labour

Duration of gestation: \_\_\_\_\_ weeks  
 Duration of birth: \_\_\_\_\_ hours  
 Medications delivered to mother during labour: \_\_\_\_\_  
 Birth Weight: \_\_\_\_\_  
 Birth Length: \_\_\_\_\_  
 APGAR: \_\_\_\_\_ (birth) \_\_\_\_\_ (5 min)

*Describe any complications at birth:*

### Growth and Development

At what age did the child:  
 Respond to sound? \_\_\_\_\_  
 Follow an object? \_\_\_\_\_  
 Hold up head? \_\_\_\_\_  
 Vocalize? \_\_\_\_\_  
 Sit alone? \_\_\_\_\_  
 Teethe? \_\_\_\_\_  
 Crawl? \_\_\_\_\_  
 Walk? \_\_\_\_\_

### Chemical Stressors

Was the child breast fed? \_\_\_\_\_  
     If yes, for how long? \_\_\_\_\_  
 Any food/juice intolerance? \_\_\_\_\_  
 \_\_\_\_\_  
 Did mom smoke while pregnant? \_\_\_\_\_  
 Did mom drink while pregnant? \_\_\_\_\_  
 Did mom have any illness while pregnant? \_\_\_\_\_  
 \_\_\_\_\_  
 Did mom take any meds or supplements during pregnancy? \_\_\_\_\_  
 \_\_\_\_\_  
 Any invasive procedures during pregnancy? (e.g. amnio, U/S) \_\_\_\_\_  
 \_\_\_\_\_  
 Any pets/smokers in the home? \_\_\_\_\_  
 \_\_\_\_\_

*Describe any vaccinations and whether any negative reactions occurred:*

*Describe number and type of medications (including antibiotics) and for what reason:*

### Psychosocial Stressors

Any difficulties with lactation? \_\_\_\_\_  
 \_\_\_\_\_  
 Any difficulties with bonding? \_\_\_\_\_  
 \_\_\_\_\_  
 Any night terrors, sleep walking, difficulty sleeping? \_\_\_\_\_  
 \_\_\_\_\_  
 Age of child entering daycare? \_\_\_\_\_  
 Average number of television per Week \_\_\_\_\_  
 Does child seem normal for age? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Traumatic stressors

Any traumas during pregnancy? (e.g. falls, accidents) \_\_\_\_\_  
 \_\_\_\_\_  
 Any evidence of birth trauma? (e.g. bruises, odd shaped head, stuck in canal, long/short birth, cord around neck, respiratory depression) \_\_\_\_\_  
 \_\_\_\_\_  
 Any falls from couches, beds, etc? \_\_\_\_\_  
 \_\_\_\_\_  
 Weight of school backpack? \_\_\_\_\_  
 Approximate hours per week spent at play \_\_\_\_\_  
 \_\_\_\_\_

*Describe any behavioural problems and age of onset:*

*Describe any additional concerns:*

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## Privacy Policy

Privacy of personal information is important to Wellness for the Body. We are committed to the collection, use and disclosure of this information in a responsible way. We will also try to be an open and transparent as to how we handle personal information.

### Personal Information

Personal information is information about an identifiable individual. Generally, the information we collect is limited to your name, home contact information, gender, and age. As part of your patient file we retain your health history; health measurements and examination results; health conditions, assessment results and diagnoses; health services provided to you or received by you; your prognosis and other opinions formed; compliance with treatment; and the reasons for your discharge and discharge recommendations. We also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent; the use, retention and privacy protection protocols. Privacy protocols comply with the privacy legislation, standards of our regulatory body, the College of Chiropractors of Ontario and the law.

### Staff Members

Staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information. These individuals include the clinic records personnel that control access to your patient file, therapists, clinic administration, and, when necessary, authorized individuals who may inspect our records as part of the regulatory activities in the public interest.

### Disclosure of Personal Information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we outline below how our clinics use and disclose this information:

- To deliver safe and effective patient care
- To enable us to contact you
- To communicate with other health care providers
- For teaching and demonstrating on an anonymous basis
- To complete and submit claims on your behalf to third party payers
- To comply with legal and regulatory requirements under the Chiropractic Act and the Regulated Health Professions Act
- To process payments and collect unpaid accounts
- For research purposes

Please do not hesitate to discuss our privacy policy with any member of our clinic staff.

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use, and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

### Patient Consent

I have reviewed the above information that explains how our clinic will use my personal information.

I agree that Wellness for the Body can collect, use, and disclose my personal information as set out above in the College's privacy code.

\_\_\_\_\_  
(Signature of parent/guardian)

\_\_\_\_\_  
(Print name)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Witness)



## **Informed Consent to Chiropractic Treatment**

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with treatment. In particular, you should note:

- While rare, some patients have experienced rib fractures or muscle and ligament strains following spinal adjustments
- There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause strokes, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustments is extremely remote
- There have been reported cases of disc injuries following cervical and lumbar spinal adjustments, although no scientific study has ever demonstrated such injuries may be caused by spinal adjustments or chiropractic treatments

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches, and other similar symptoms. Chiropractic care contributes to your overall wellbeing. The risk of injuries or complications from chiropractic treatment is substantially lower than those associated with many medical treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and the treatment of my child in particular (including spinal adjustment) as well as the contents of this consent. I consent to the chiropractic treatments and assessment of my child offered or recommended to me by my chiropractor including spinal adjustment. I intend this consent to apply to all my child's present and future chiropractic care.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Name of parent/guardian: (print) \_\_\_\_\_ (Signature) \_\_\_\_\_

Witness: (print) \_\_\_\_\_ (Signature) \_\_\_\_\_

## **Informed consent to Acupuncture**

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary including needling, guasha, laser, electroacupuncture, and other techniques within the scope of practice of acupuncturists. These procedures may be performed by the acupuncturists or another duly authorized person in the clinic.

I have had the opportunity to discuss with the acupuncturist and/or with other office or clinic personnel the nature and purpose of acupuncture care and other procedures. I understand that the results are not guaranteed.

I have been advised that all insertion needles are pre-sterilized and disposable. I further understand and am informed that, as with all health care, the practice of acupuncture possesses slight risks from treatment, including, but not limited to, temporary soreness, bruising, blistering, nausea, fainting, bleeding, infection and shock. I do not expect the acupuncturist to anticipate and explain all the risks and complications and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, are in my child's best interest.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures(s) on my child's behalf. I intend this consent form to cover the entire course of treatment for my child's present condition and for any future condition(s) for which I seek treatment.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Name of parent/guardian: (print) \_\_\_\_\_ (Signature) \_\_\_\_\_

Witness: (print) \_\_\_\_\_ (Signature) \_\_\_\_\_