**New Sudbury Chiropractic & Wellness Centre**
**1100 Lasalle Blvd., Sudbury, ON. P3A 1X9**
**(705) 521-1100**
**www.newsudburychiropractic.ca**

# Welcome to Our Office
# Outline of Procedures for Adolescent New Patients

## STEP ONE

All new patients are requested to fill out a confidential ***Patient Health Record***.

## STEP TWO

Your first ***consultation*** with the doctor to discuss your child's health problems.

## STEP THREE

Diagnostic chiropractic, orthopedic and neurological ***examination*** procedures to determine if chiropractic care is appropriate for your child's condition.

## STEP FOUR

The doctor will advise you as to the need of additional procedures such as ***laboratory tests and x-rays***, if necessary.

## STEP FIVE

If your child's case requires immediate attention, ***emergency first aid treatment*** will be administered.

## STEP SIX

You will be advised as to a time you can return for a ***Special Appointment***. Our records show that those patients who respond most rapidly to care are those who have learned to help themselves. We give you, your family and friends the opportunity to learn what you can do to help us return your child to health more quickly and completely, and what one needs to do to stay healthy.

## STEP SEVEN

You will be advised as to a time you can return for your child's ***Report of Findings*** when your doctor will inform you as to your child's examination results and whether or not your case has been accepted. If accepted your child's recommended treatment program will be explained to you. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

## STEP SEVEN

Chiropractic care will begin and continue as scheduled until your condition has been fully corrected, or until the maximum possible improvement has been obtained.

***To save time and allow us to better serve you, please complete all questions on the next pages. Thank You.***

**Turn over»**

**New Sudbury Chiropractic and Wellness Centre 1100 Lasalle blvd. Sudbury ON. P3A 1X9 (705) 521-1100**

**Dr. Michael Staffen** **Dr. Brandon Jones**

Date: Patient No.

# Adolescent Health Record

## PERSONAL HEALTH HISTORY

Name: _____ Birthdate: ____/____/____ Age: _____ Gender: ☐M ☐F
Parents/Guardians Name: _____
Address: _____ City: _____ Province: _____Postal Code:_____
Home Ph: _____ Parents Work Ph: _____ Parents Cell Ph: _____
Physician's Name: _____ Extended Health Coverage: ☐ Yes ☐ No ☐ Not sure
Referred To This Office By: _____
How will you be taking care of your account? ☐ Cash ☐ Cheque ☐ Debit ☐ Visa ☐ MasterCard

## NATURE OF THIS VISIT

☐ Wellness Checkup
☐ Symptoms/Complaint: _____
_____
Other doctors seen for this condition: ☐No ☐Yes: Who? _____
Type of Treatment: _____ Results: _____
When did this condition begin? _____ Has this condition occurred before? ☐No ☐Yes, _____
What aggravates the condition? _____
What relieves the condition? _____
Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better
List any medications currently taking: _____
_____

## PRENATAL/BIRTH HISTORY

Who did the mother see for prenatal care? ☐Midwife ☐Obstetrician ☐Other: _____

Were there any problems during the pregnancy? ☐No ☐C Section ☐Yes, _____

Delivery Method: ☐Vaginal ☐Planned C-Section ☐Emergency C-Section

Was the birth assisted: ☐No ☐Yes, How? ☐Induction ☐Forceps ☐Vacuum extraction

## SLEEPING PATTERNS & POSITIONS

Sleeping position? ☐Back ☐Side ☐Front/Stomach

Are there any sleeping problems? ☐No ☐Yes: _____

How many hours of sleep during the night? _____

## IMMUNIZATIONS

Vaccinated? ☐Not Yet ☐No ☐Yes Were there any visible reactions?_____

## FAMILY HEALTH HISTORY

Are there any conditions/diseases that run in your family? ☐No ☐Yes, _____
_____
Is there asthma or allergies in the family? ☐No ☐ Yes ☐Whom? _____
Are there any pets in the home? ☐No ☐Yes, _____
Are there any smokers in the home? ☐No ☐Yes, _____

**New Sudbury Chiropractic and Wellness Centre 1100 Lasalle blvd. Sudbury ON. P3A 1X9 (705) 521-1100**
**Dr. Michael Staffen Dr. Brandon Jones**

Date: Patient No.

## HAS THE CHILD EXPERIENCED ANY OF THE FOLLOWING

| | | | | | |
|---|---|---|---|---|---|
| ☐Accidents/Falls | When?_____ | Treatment? _____ | ☐Allergies | When? _____ | Treatment? _____ |
| ☐Asthma | When?_____ | Treatment? _____ | ☐Colds | When? _____ | Treatment? _____ |
| ☐Constipation | When? _____ | Treatment? _____ | ☐Diarrhea | When? _____ | Treatment? _____ |
| ☐Ear Infections | When? _____ | Treatment? _____ | ☐Fevers | When? _____ | Treatment? _____ |
| ☐Flu | When? _____ | Treatment? _____ | ☐Headaches | When? _____ | Treatment? _____ |
| ☐Leg (growing) pains | When? _____ | Treatment? _____ | ☐Meningitis | When? _____ | Treatment? _____ |
| ☐Surgery | When? _____ | Treatment? _____ | ☐Other _____ | | |

## LIFESTYLE

### Nutrition

How is the child overall nutrition: ☐ Poor ☐ Good ☐ Excellent

How often does the child consume the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Fruits | ☐ Always | ☐ Couple times per week | ☐ Never | Vegetables | ☐ Always | ☐ Couple times per week | ☐ Never |
| Junk Food | ☐ Always | ☐ Couple times per week | ☐ Never | Pop/Juices | ☐ Always | ☐ Couple times per week | ☐ Never |
| Vitamins | ☐ Always | ☐ Couple times per week | ☐ Never | Cigarettes | ☐ Always | ☐ Couple times per week | ☐ Never |

Do you have any nutritional concerns for the child? ☐No ☐Yes,_____

_____

### Exercise

How often does the child exercise ☐ Daily ☐ Couple time per week ☐ Infrequently

Does the child participate in organized physical activities ☐ No ☐ Yes,_____

_____

### Stress

Overall how is the child's stress level ☐ Low ☐ High (school, work, home)_____

_____

### Health

How would you rate the child's overall health on the following scale:

0 1 2 3 4 5 6 7 8 9 10

Least Healthy Most Healthy

### Commitment to Care

Are you interested in (circle): **A)** Reducing symptoms (Bandaid Care)

**OR**

**B)** Reducing symptoms and optimizing health (Corrective/ Wellness Care)