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 Pediatric 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 EIGHT

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.

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Dr. Michael Staffen Dr. Brandon Jones

Date:

Patient No.

Pediatric 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 child's condition? _____
What relieves the child's condition? _____
Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better

List any medications the child is currently taking: _____
_____

PRENATAL HISTORY

Who did the mother see for prenatal care? ☐Midwife ☐Obstetrician ☐Other: _____
Were there any problems during the pregnancy? ☐No ☐Yes, _____
_____

BIRTH HISTORY

Labor: How long was the: 1. first stage (dilation to 10cm)? _____ 2. second stage (pushing)? _____
Location of Birth: ☐Home ☐Hospital ☐Other: _____
Delivery Method: ☐Vaginal ☐Planned C-Section ☐Emergency C-Section
Who delivered the baby? ☐Midwife ☐Obstetrician ☐Other: _____
Was the birth assisted: ☐No ☐Yes, How? ☐Induction ☐Forceps ☐Vacuum extraction
Were any medications used for pain control? ☐No ☐Yes, What medications? ☐ Epidural ☐ Other: _____
Type of presentation? ☐Head (anterior or posterior) ☐Face ☐ Breech
What was the APGAR score? ☐10 ☐9 ☐8 ☐7 ☐6 or under

FEEDING & ELIMINATION HISTORY

For the child <u>not</u> consuming solid foods yet:
How is the child feeding: ☐ Breast Fed ☐ Bottle Fed How Often? _____

For the child consuming solid foods:
At what age were solid foods introduced? _____
If the child was breast fed, how long did he/she do so? _____
Is feeding a pleasant experience for mother and baby? ☐Yes ☐No
How would you describe the child's eating habits? ☐ Poor ☐ Good ☐ Excellent

How many wet diapers does the child have per day? _____
How many soiled diapers does the child have per day? _____

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Date: Patient No.

SLEEPING PATTERNS & POSITIONS

What position does the baby sleep in? ☐Back ☐Side ☐Front/Stomach
Are there any sleeping problems? ☐No ☐Yes: _____
How many hours does the baby sleep during the night? _____

CRYING PATTERNS

Does the child experience excessive crying? ☐No ☐Yes
If Yes, what is the: Number of hours/day _____ Number of days/week _____ Number of weeks _____
Has the child cried constantly for more than 2 hours? ☐Yes ☐No
Does the child appear too weak to cry? ☐Yes ☐No

IMMUNIZATIONS

Is the child vaccinated? ☐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, _____

HAS YOUR 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	When?_____	Treatment? _____
☐Other	When?_____	Treatment? _____

MILESTONES

At what age did the child:

First held head up _____
Sitting up _____
Crawling _____
Standing up _____

Walking _____
Talking _____
Toilet Trained:
(Day/Night) _____/_____