Progressive Family Wellness Centre

2100 Ellesmere Rd Suite 324, Scarborough, Ontario, M1H 3B7, 416-439-9979, Fax: 416-439-6550
www.progressivewellness.ca

PEDIATRIC CONFIDENTIAL APPLICATION FOR CARE

Personal Information

Name: _____ Date: _____

Address: _____ Parent's Home Phone: _____

City, Province, Postal Code: _____ Parent's Work Phone: _____

Parents & Siblings names: _____ Parent's Cell Phone: _____

Date of Birth: _____ Age: _____ Gender: ❑ Male ❑ Female ❑ Non-binary Height:_____ Weight_____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Do you have extended health coverage? ❑Yes ❑No Annual Chiropractic Coverage Amount: _____ Orthotics: ❑Yes ❑No

Previous Chiropractic Care? ❑Yes ❑No Chiropractor's name:_____ Family Physician: _____

Who may we thank for referring you? _____

History of Complaint

Please identify the condition(s) that brought you into this office: Primary:_____

Secondary:_____ Third:_____ Fourth:_____

On a scale of **0 -10** with **0** being no pain and **10** being the worst pain, rate your above complaints by ***entering the number:***

Primary Complaint: _____ When did the problem begin? _____

Secondary Complaint: _____ When did the problem begin? _____

Third Complaint: _____ When did the problem begin? _____

Fourth Complaint: _____ When did the problem begin? _____

Primary Complaint Details

When is it at its worst? ❑AM ❑Mid Day ❑PM ❑Late PM

How long does it last? ❑Constant ❑It Comes & Goes During the Day ❑It Comes & Goes Throughout the Week

What aggravates your symptoms? ❑Lying Down ❑Sitting ❑Standing ❑Bending ❑Lifting ❑Walking ❑Nothing

What relieves your symptoms? ❑Rest ❑Ice ❑Heat ❑Massage ❑Movement ❑Medication ❑Nothing

Character of Pain: ❑Sharp ❑Dull ❑Ache ❑Burn ❑Throb ❑Spasm ❑Numb ❑Tingling ❑Shooting ❑Sore ❑Stabbing

Have you experienced any travelling pain? (eg. pain that begins in one area & travels to another) ❑Yes ❑No

Does the pain travel into your: ❑Arm/Shoulder ❑Leg ❑Does Not Travel Is this condition getting worse? ❑Yes ❑No ❑Same

Does this interfere with: ❑Work ❑Sleep ❑Hobbies ❑Family Activities ❑Daily Routine ❑Sports/Exercise

Were other forms of treatment tried: ❑Yes ❑No If yes, please state what type of treatment: _____

When?_____Results:_____

Have you ever had spinal x-rays taken? ❑Yes ❑No If yes, what year were they taken? _____ Where? _____

Identify any **other injuries to your spine**, minor or major, that the doctor should know about: _____

_____

Past History

What type of birth did you have? (eg. natural, c-section) _____

Were any assistive devices used in the birthing process? (eg. vacuum, forceps) _____

Were there any issues as an infant? (eg. latching, colicky) _____

Were there any issues with learning or development as a child? _____

Have you had any past illnesses? _____

Please list any medications (past or present) you have been on: _____

_____

Please list any major **surgeries** you've had and their approximate dates:

_____

_____

_____

Accident/Injury History

Car Accidents (please list all)

Year:_____ Injury:_____ Treatment:_____

Year:_____ Injury:_____ Treatment:_____

Year:_____ Injury:_____ Treatment:_____

Sports Injuries (please list all)

Year:_____ Injury:_____ Treatment:_____

Year:_____ Injury:_____ Treatment:_____

Year:_____ Injury:_____ Treatment:_____

Slips/Falls: (please list all)

Year:_____ Injury:_____ Treatment:_____

Year:_____ Injury:_____ Treatment:_____

Year:_____ Injury:_____ Treatment:_____

Family History

Does anyone in your family suffer with the same condition(s)? ❑Yes ❑No

If yes, whom? ❑Father ❑Mother ❑Sister ❑Brother ❑Grandmother ❑Grandfather ❑Son(s) ❑Daughter(s)

Have they ever been treated for their condition? ❑Yes ❑No ❑I don't know

Are there any other **hereditary conditions** the doctor should be aware of? _____

_____

General Health History

Please **check [✓]** the box for symptoms you are **currently experiencing**:

Cranial & Cervical Nerves

- ❑ Neck Pain
- ❑ Pain into your shoulders/arms/hands
- ❑ Numbness/tingling in arms/hands
- ❑ Coldness in hands
- ❑ Weakness in grip
- ❑ TMJ pain/clicking
- ❑ Headaches
- ❑ Earaches
- ❑ Ringing in ears
- ❑ Hearing disturbances
- ❑ Visual disturbances
- ❑ Dizziness
- ❑ Lightheadedness
- ❑ Low energy/fatigue
- ❑ Loss of sleep
- ❑ Anxiety/Depression
- ❑ Thyroid conditions
- ❑ Sinusitis
- ❑ Allergies/hay fever
- ❑ Frequent colds/flu

Upper Thoracic Nerves

- ❑ Upper back pain
- ❑ Heart palpitations
- ❑ Heart murmurs
- ❑ Tachycardia
- ❑ Heart attacks/angina
- ❑ Recurrent lung infections/bronchitis
- ❑ Asthma/wheezing
- ❑ Shortness of breath
- ❑ Pain on deep inspiration/expiration

General Conditions:

- ❑ Stroke
- ❑ Heart Disease
- ❑ Cancer
- ❑ Diabetes

Lower Thoracic Nerves

- ❑ Mid back pain
- ❑ Pain into your ribs/chest
- ❑ Indigestion/heartburn
- ❑ Reflux
- ❑ Nausea
- ❑ Ulcers/gastritis
- ❑ Tired/irritable after eating or when you haven't eaten for a while
- ❑ Abdominal bloating
- ❑ Ulcerative intestinal conditions
- ❑ Skin disturbances
- ❑ Hypoglycemia

Lumbar & Sacral Nerves

- ❑ Low back pain
- ❑ Pain into your hips/legs/feet
- ❑ Numbness/tingling in your legs/feet
- ❑ Coldness in legs/feet
- ❑ Muscle cramps in your legs/feet
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Constipation/diarrhea
- ❑ Recurrent bladder infections
- ❑ Frequent/difficulty urinating

Is there anything else which may help us to better understand you, which has not been discussed? ❑ Yes ❑ No

Please Explain: _____

TO BE READ & COMPLETED IN OFFICE:

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS & CARE

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients of benefits and risks including sprain/strain, rib fracture and disc herniation. With neck problems, there have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke-like occurrences, which are usually of a temporary nature. The chances of this happening to you are less than one in ten million. Tests, with or without x-rays have been performed to minimize these risks to yourself. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions. If you have any questions about this, please ask your chiropractor.

I have read the above statement and consent to treatment.

Guardian's Signature: _____ Date: _____