



PEDIATRIC HEALTH PROFILE

First Name: _____ Last Name: _____

Preferred Name: _____ Prefix/Title: _____

Cell: _____ Home: _____

Address: _____
(Street) (City, Province) (Postal Code)

Date of Birth: _____ Gender: _____ Sex: M / F
(DD / MM / YYYY)

Alberta Health Number: _____ Guardian: _____

Emergency Contact Phone: _____ Emergency Contact Name: _____

Emergency Contact Relationship: _____

=====

Family Doctor: _____

Family Doctor Phone: _____ Family Doctor Email: _____

Name of referring professional: _____

Referring Prof. Phone: _____ Referring Prof. Email: _____

=====

Are you seeking care due to a motor vehicle collision, work-related injury or WCB claim?

☐ No ☐ Yes

Which of our chiropractors were you referred to? As well, we like to acknowledge those who recommend us. We'd love to know how you heard of our practice.

Names & ages of siblings:

(1) Name of sibling & age: _____

(2) Name of sibling & age: _____

(3) Name of sibling & age: _____

(4) Name of sibling & age: _____

Your child is attending: ☐ Seeking wellness care ☐ For a specific concern (state below)

What is your specific concern & expectation for the visit:

What care has been received (if any) and what Practitioners have been consulted for this concern?

- ☐ 1. No other care received. ☐ 2. No other practitioners have been consulted. ☐ 3. Practitioners consulted & care administered (list here)

If (3) above, list Practitioners & type of care administered (please list level of results as well):

Onset of care that brings your child to this appointment:

☐ Began (DD/MM/YYYY) _____

☐ Associated with an event? (State) _____

☐ Nature of issue/complaint? _____

☐ How often is an issue? _____

☐ What improves it? _____

☐ What worsens it? _____

Duration of the concern/episode it:

☐ Minutes _____ ☐ Hours _____ ☐ Days _____ ☐ Months _____ ☐ Years _____

Birth History:**Assisted birth (select all that apply):**

☐ Epidural ☐ Forceps ☐ Vacuum Extraction ☐ C-section ☐ Induced Labour ☐ None

Medications delivered to mother at birth? ☐ Yes ☐ No

If yes, what? _____

Gestational age at birth? _____

Duration of active labour? _____

Babies birth weight? _____

Any feeding issues (latching/tongue tie, etc)? _____

Complications to baby at birth:

☐ Bruising at birth ☐ Odd shaped head at birth ☐ Baby was stuck in birth canal ☐ Birth was fast

☐ Birth was excessively long ☐ Baby had respiratory depression ☐ Cord was around baby's neck

☐ Other birth traumas (specify): _____

Does your child's sleeping pattern seem normal to you? ☐ Yes ☐ No

Additional comments? _____

GENERAL HEALTH HISTORY (indicate any symptom(s) experienced in the past year):**Neurological**

☐ allergy	☐ chills	☐ convulsions	☐ dizziness
☐ fainting	☐ fevers	☐ headaches	☐ loss of sleep
☐ nervousness	☐ depression	☐ neuralgia	☐ numbness
☐ sweats	☐ loss of weight	☐ tremors	

Muscle & Joint

☐ arthritis	☐ bursitis	☐ foot trouble	☐ hernia
☐ low back pain	☐ neck pain	☐ neck stiffness	☐ pain between shoulders

GENERAL HEALTH HISTORY (cont'd) (indicate any symptom(s) experienced in the past year):**Respiratory**

- | | | | |
|--|--|---|---|
| ☐ chest pain | ☐ chronic cough | ☐ difficulty breathing | ☐ spitting blood |
| ☐ throat phlegm | ☐ wheezing | | |

Eyes, Ears, Nose & Throat

- | | | | |
|---|--|---|--|
| ☐ colds | ☐ crossed eyes | ☐ deafness | ☐ dental decay |
| ☐ asthma | ☐ ear aches | ☐ ear noises | ☐ vomit blood |
| ☐ sinus infections | ☐ enlarged glands | ☐ enlarged thyroid | ☐ sore throat |
| ☐ tonsillitis | ☐ eye pain | ☐ failing vision | ☐ far sighted |
| ☐ gum trouble | ☐ hay fever | ☐ hoarseness | ☐ nasal obstruction |
| ☐ near sighted | ☐ nosebleeds | | |

Cardiovascular

- | | | | |
|--|---|--|--|
| ☐ rapid heart beats | ☐ slow heart beats | ☐ swelling of ankle | ☐ hardening of arteries |
| ☐ pain over heart | ☐ poor circulation | ☐ high blood pressure | ☐ low blood pressure |

Gastrointestinal

- | | | | |
|---|---|---|---|
| ☐ excessive hunger | ☐ burping or gas | ☐ liver trouble | ☐ colitis |
| ☐ colon trouble | ☐ constipation | ☐ diarrhea | ☐ difficult digestion |
| ☐ stomach pain | ☐ hemorrhoids | ☐ intestinal worms | ☐ jaundice |
| ☐ poor appetite | ☐ nausea | ☐ vomiting | ☐ gall bladder trouble |

Skin

- | | | | |
|----------------------------------|--|---|---|
| ☐ boils | ☐ bruise easily | ☐ dryness | ☐ hives or allergy |
| ☐ itching | ☐ skin rash | ☐ varicose veins | |

Genitourinary

- | | | | |
|---|--|---|--|
| ☐ bed wetting | ☐ blood in urine | ☐ frequent urination | ☐ loss control of urine |
| ☐ kidney infection | ☐ painful urination | ☐ prostate trouble | ☐ pus in urine |
| ☐ smell of urine | | | |

Pain or Numbness in

- | | | | |
|------------------------------------|-----------------------------------|---|-------------------------------|
| ☐ shoulders | ☐ arms | ☐ hands | ☐ hips |
| ☐ legs | ☐ knees | ☐ ankles | ☐ feet |
| ☐ tail bone | ☐ sciatica | ☐ swollen joints | |

VIBE HEALTH & SPINE Inc.

Suite 310, 1918 Kensington Rd. NW, Calgary, Alberta T2N 3R5

Phone: 403-266-2283 Fax: 403-351-1690

Chiropractic care for children focuses on many types of stressors to the developing Spine & Nervous Systems.

As a result, it is important to know the following:

Chemical Stressors

- ☐ Child was breast-fed as an infant? (how long) _____
- ☐ Food/Juice intolerance (type) _____
- ☐ Supplements/vitamins administered to the child: _____
- ☐ Child consumes sugar on a regular basis: _____
- ☐ Smokers are present in the home: _____
- ☐ Pets are present in the home (type(s)/how many): _____
- ☐ Child has received vaccinations: _____
- ☐ Child has received antibiotics? How often? _____
- ☐ Child has reacted to medications (indicate): _____

Psychosocial Stressors

- ☐ Child has difficulty with bonding
- ☐ Child has behavioural problems (state onset & details below)
- ☐ Child has difficulty sleeping (please explain below)
- ☐ Child and siblings do not get along
- ☐ Child has night terrors
- ☐ Child sleep walks
- ☐ Child does not enjoy and/or excel in school

Physical Stressors

- ☐ Traumas (falls, accidents) during pregnancy: _____
- ☐ Falls (incl. couches, beds, change, tables, stairs, etc): _____
- ☐ Accidents (specify): _____
- ☐ Trauma(s) with bruising, cuts, stitches, fractures: _____
- ☐ Child participates in the following activities (list): _____

Child crawled prior to walking: ☐ Yes ☐ No

HEALTHCARE TEAM:

Family Physician

Name: _____

Location: _____

Paediatrician

Name: _____

Location: _____

Dentist

Name: _____

Location: _____

Naturopathic Doctor/Homeopath

Name: _____

Location: _____

Other Specialist

Name: _____

Location: _____

Please include any other information that you think we should know:

Communication

Appointment Notifications and Reminders

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

Email

☐ Email 2 days prior to appointment

Text Message (SMS)

Standard messaging & data rates may apply, messaging frequency can vary and you can update your preferences anytime.

☐ Text Messages (SMS) 2 hours prior to appointment

News and Special Promotions

☐ Yes, I would like to receive clinic updates and health and wellness information from the Vibe team of Practitioners. This is usually sent on a monthly basis.

Pediatric Intake Form - Consents

Accuracy of Information

☐ I certify that the above medical information is correct to my knowledge. - Required

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree. - Required

Cancellation, No Show and Late Arrival Policies

A credit card is required to reserve appointments of 1 hour (or greater) in length.

When an appointment is scheduled, it is reserved exclusively for you. If you cancel or miss the appointment without sufficient notice, it prevents another individual from booking that time slot resulting in lost opportunity for the therapist to provide their service and generate income. In our desire to be effective and fair to all clients, the following policies are honoured:

CANCELLATIONS: A FULL 24-hour advance notice is required when cancelling an appointment. If you are unable to give 24 hours advance notice you will be charged 50% of the booked service fee.

NO SHOWS: All no shows will be charged 50% of the booked service fee.

Phone calls and emails are time stamped therefore notifications delivered in this manner are subject to our Cancellation and No Show policies.

Cancellation and No Show fees will be automatically charged to your credit card.

LATE ARRIVALS: If you arrive late for your scheduled appointment, your appointment will still end at the scheduled time and you will be charged the full fee for the booked service. It is not the duty of the therapist to accommodate missed time and cannot be demanded.

☐ I confirm that I have read, fully understood, agree to the above policy, and agree to pay the fees associated with the service booked. I authorize Vibe Health & Spine to charge my credit care for any treatment that is not cancelled at least 24 hours prior to the booked service. I certify that I am an authorized user of the credit card on file and will not dispute this scheduled transaction with my bank or credit card company as long as the transaction corresponds to the terms indicated in this consent form. - Required

Signature (parent/guardian)

Date