ALCONA CHIROPRACTIC & NATURAL HEALTH

Dr. Mark Kohut, B.HK, D.C.
1425 7th line
Innisfil, ON L9S 4G3
Telephone: (705) 431-0505

Child Intake Form (3 – 12 years)

Name: _____ Date: _____

Age: _____ Parent Names: _____

Address:_____City_____Postal Code _____

Parent Telephone: (Cell)_____ (Home/Bus) _____

Parent E-Mail Address:_____

Date of birth: m___ d___ y_____ Weight: _____ Height: _____ Gender: M F

Medical doctor: _____ Address: _____Tel.: _____

How did you hear about our office?
( ) Referral - Whom may we thank for referring you to our office?_____
( ) Sign
( ) Yellow Pages
( ) Other - _____

Here at Alcona Chiropractic, we focus on your potential to be healthy! When a patient seeks chiropractic care, it is essential that we are both working towards the same objective. Please take a moment to familiarize yourself with the following terms:

The goal of Chiropractic: To remove any interference from the spine and spinal nerves, in order to allow the brain to fully communicate with the body.

Subluxation: A misalignment or restricted movement in the spine which causes interference to the transmission of nerve impulses, resulting in a lessening of the body's ability to heal and express its health potential.

Adjustment: An adjustment is the specific application of movement used to facilitate the body's correction of subluxation.

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General Health History

Rate your child's current level of Health

Place an '**X**' where you believe your child's current level of health to be.
Place an '**O**' where you would like your child's health to be.

Has your child ever received chiropractic care?

Yes ***No***

If yes, previous Doctor's name and last visit date?_____

Present Health or Developmental Concerns:

_____

_____

_____

When was this problem first noticed?

_____

Is this becoming worse?

_____

Other professionals seen for this condition?

_____

Results with that treatment?

_____

_____

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Please try to list your child's top stresses in each category:

1. Physical Stresses (minor falls, poor posture, accidents, birth trauma, etc.)

_____

2. Chemical Stress (unhealthy foods, lacking water intake, environmental toxins, etc.)

_____

3. Psychological Stresses (relationships, school demands, busy schedule, etc.)

_____

Sleep Patterns

Do you consider the child's sleeping pattern normal? Yes No

If No, please explain

_____

Eating Patterns

Do you consider the child's eating patterns normal? Yes No

If No, please explain

_____

Activity Patterns

Is your child able to participate in regular physical activity? Yes No

If No, please explain

_____

Goals of care:

As a result of chiropractic care, I would like my child to:

( ) Feel better quickly

( ) Ensure that health concerns do not become an ongoing problem in the future

( ) Have a healthier body by keeping their nervous system healthy

( ) Live an active, healthy lifestyle to 80, 90, or 100 years of age!

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Informed Consent to Chiropractic Care

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although highly uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

Dated this_____ day of_____, 20_____.

_____ _____

Patient Signature (Legal Guardian) **Witness Signature**

Name:_____ **Name:**_____

(please print) (please print)

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Payment Agreement & Policy

- Payment is due at the time of service.
- We offer **pre-paid options** for chiropractic care plans. Pre-paid plans provide an administrative discount and remove the need for patients to spend time being processed at the front desk each visit.
- We accept the following forms of payment:
  - Cash
  - Cheque
  - Debit Card
  - Credit Card

For practice members with insurance plans, we will provide you with the proper documentation to be reimbursed as quickly as possible. We can never guarantee that your insurance company will reimburse your care fees. You are ultimately responsible for the investment into your care at our office.

For practice members without insurance coverage, we will print out a yearly statement for income tax deductions at your request.

Cancellation Policy

We require a minimum of 24 hours notice to reschedule, postpone, or cancel an appointment.

Failure to provide **24 hours notice** will result in a **$25** charge. This charge will appear as a 'Missed Appointment Fee' on your next invoice/statement.

By signing this agreement, you are indicating that you understand and agree to the terms of service explained above.

Patient Name :_____

Signature:_____ Date:_____