



OKANAGAN HEALTH & PERFORMANCE

Family & Sports Chiropractic, Massage Therapy & Physiotherapy

104-1100 Lawrence Ave, Kelowna, BC, V1Y-6M4
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(250) 860-6295
Fax: (250) 860-2424

Dear Patient, welcome to **Okanagan Health & Performance**. Thank you for entrusting us with your health.

PERSONAL INFORMATION

First Name _____ Initial _____ Last Name _____ Care Card # _____

Birthdate: MM _____ DD _____ YY _____ Age _____ Gender: M _____ F _____

Address _____ City _____ Prov _____ Postal Code _____

Parent's Name(s) _____ Phone: (H) _____ (W) _____ (C) _____

Work _____ Emergency Contact _____ Phone _____

Email _____ Marital Status: _____ Number of children _____

How did you hear about us? Referred by: _____ Phone book _____ Sign _____ Other _____

HEALTH CARE COVERAGE/CLAIM INFORMATION

Is this a motor vehicle related injury (ICBC)? Yes _____ No _____ If yes, claim # _____

PREVIOUS CHIROPRACTIC CARE

Previous chiropractic care _____ Y _____ N Name of chiropractor _____ Phone _____

Date last seen _____ Treatment _____ Results: _____ Good _____ Fair _____ Poor

HEALTH HISTORY AND INFORMATION

Birth Weight _____ Current Weight _____ Height/Length _____

Type of Birth: _____ Length of Delivery _____ Baby's APGAR score _____

Birth trauma, infection, jaundice, etc. _____

Congenital Anomalies/childhood diseases _____

Baby's Feeding Habits: _____ breast _____ bottle _____ formula

Current Diet _____

Quality of Sleep _____ Number of Hours/night _____

Medical Practitioner's Name _____ Phone _____

Date last seen _____ Reason for visit/comments _____

Has the child been on any medications or antibiotics yet? _____

Current Medications/Vitamins _____

Immunization/Vaccinations _____

Affected symptoms and Conditons

<input type="checkbox"/> Anemia	<input type="checkbox"/> Colds/Flu	<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Poor appetite
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Colic	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hyperactivity/ADD	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Digestive Disorders	<input type="checkbox"/> Muscle jerking	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bone Disease	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Neuritis	

INFORMED CONSENT TO CHIROPRACTIC CARE (please read carefully)

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- 1) While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments
- 2) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairments, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.
- 3) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of the Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all of my child's present and future chiropractic care.

Patient Signature (Legal Guardian)

Date

Witness
