

INNER HARMONY FAMILY CHIROPRACTIC
DR. DAVID VECCHIO, D.C.
272 ST. MARIE STREET
COLLINGWOOD, ON L9Y 3K7
(705) 446-9690

CONFIDENTIAL PEDIATRIC CONSULTATION

Name: _____ Date: _____

Date of Birth: (dd/mm/yy) _____ Sex: M / F

Address: _____ Town: _____ Postal Code: _____

Home# _____

Parent's Work# _____ Parent's Cell# _____

Parent's Email: _____
(we do not trade/share any of our email addresses)

How did you hear about our clinic? _____
(Please be specific)

Main reason for bringing your child into our clinic today? _____

What goals would you like to achieve for your child's health? _____

Previous Chiropractic Care: No () Yes ()

If yes, name of Chiropractor and date of last visit _____

If your child is not experiencing any symptoms and you simply want wellness services, please check here _____ and skip this section. If there are any specific health concerns, please answer the following questions:

Describe the nature of your child's symptoms or health concerns: _____

When and how did this problem first start? _____

Please list any broken bones, injuries, accidents, falls or surgeries your child has experienced:

Has your child ever been hospitalized? _____

If so, please describe: _____

Does your child have difficulties with any of the following:

sleeping _____

breathing problems _____

ear infections _____

learning _____

concentration _____

behaviour _____

bed-wetting _____

allergies _____

colds/infections _____

constipation _____

seizures _____

temper tantrums _____

growing pains _____

eating _____

asthma _____

ADHD _____

colic _____

scoliosis _____

Where there any complications during the pregnancy or delivery of your child?

If so, please describe: _____

Was the delivery vaginal _____ or caesarean? _____

Were any assistive devices used? forceps _____ vacuum _____ other _____

Has your child ever had a reaction to a vaccination? _____

If so, please describe: _____

OTHER CONDITIONS OR CONCERNS: _____

I have read and agree that all information provided is accurate to the best of my knowledge. I also agree, that once explained to me, I will participate in my child's health care and policies and agreements that go with my child's chiropractic care. I understand and agree that health and accident insurance policies are an arrangement between myself and the carrier. I will be provided all the necessary receipts to be reimbursed. I understand that if I suspend or terminate my child's care, all fees are due and payable for services rendered. I hereby consent to a preliminary consultation, examination, scans or other diagnostic testing that will assist the doctor in determining if my child is a chiropractic case. If chiropractic care is prescribed, I also agree to chiropractic adjustments, based on my decision to choose chiropractic care for my child. I understand and agree that as in all health care, there are some slight risks and that my child has been examined in order to determine if they are at risk and the doctor has explained all aspects of my child's care. I will rely on the doctor's judgement during my child's course of care. I intend this consent to cover the entire course of my child's care in this clinic.

Patient Name: _____ Date: _____

Parent or Legal Guardian Signature: _____

Witness Signature (C.H.A.) _____