Binbrook Chiropractic & PhysiotherapyDr. Harnek Gill B.Sc.,D.C
3064 Hwy 56 Binbrook, On L0R1C0

Child History Form

Please complete the following as completely as possible. If you need assistance, please ask the front desk staff and they will be glad to assist you.

Child's Name: _____Date: _____
Parent(s) Name: _____
Sibling(s) Name(s) (Ages): _____
Address:_____ City: _____ Prov. _____
Postal Code: _____ Home Phone: (____) _____ Bus Phone: (____) _____
Date of Birth: _____ Age: ____ Gender: ☐ M ☐ F Referred by: _____
Has your child ever received chiropractic care? ☐ Yes ☐ No If yes, previous DC's name and last visit date?
_____
Name of Medical Doctor:_____
Date of last MD visit and reason:_____

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

PARENT(S) NAME(S): _____ WORK TEL:_____
I hereby authorize and consent to the chiropractic evaluation and care of my child.
PARENT/GUARDIAN SIGNATURE: _____ DATE: _____
WITNESS SIGNATURE:_____

Present Health Complaints/Concerns:

Major:_____
_____
Minor:_____
_____
When did this problem begin?_____
Is this problem: ☐ Occasional ☐ Frequent ☐ Constant ☐ Intermittent
Does problem radiate? ☐ Yes ☐ No If yes, where? _____
What makes this worse? _____
What makes this better? _____
Is the problem worse during a certain time of the day? ☐ Yes ☐ No If yes, when?_____
Does this interfere with the child's ☐ Sleep? ☐ Eating? ☐ Daily Routine?
Is this becoming worse? _____
Other professionals seen for this condition? _____
Results with that treatment? _____
_____

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS: (please check if your child has had any of the following)

☐ Headaches	☐ Loss Of Taste	☐ Weight Gain	☐ Upper Back Pain
☐ Dizziness	☐ Light Sensitivity	☐ Dental Problems	☐ Neck Pain
☐ Fainting	☐ Face Flushed	☐ Fevers	☐ Low Back Pain
☐ Fatigue	☐ Cold Sweats	☐ Heart Palpitations	☐ Radiating Pain
☐ Irritability	☐ Bronchitis	☐ Chest Pressure	☐ Stiffness
☐ Depression	☐ Pneumonia	☐ Breast Pain	☐ Reduced Mobility
☐ Loss Of Balance	☐ Difficulty Breathing	☐ Frequent Colds	☐ Numbness In Leg(s)
☐ Loss Of Concentration	☐ Shortness Of Breath	☐ Sinus Congestion	☐ Numbness In Feet
☐ Loss Of Memory	☐ Asthma	☐ Sore Throats	☐ Numbness In Hand(s)
☐ Ears Buzzing	☐ Urinary Problems	☐ Ear Pain / Infections	☐ Weakness
☐ Poor Coordination	☐ Constipation	☐ Allergies	☐ Muscle Cramps
☐ Vision Changes	☐ Diarrhea	☐ Heartburn	☐ Sleeping Problems
☐ Loss Of Smell	☐ Weight Loss	☐ Bloating / Gas	

☐ Other: _____

Has there been a change in your child's eating habits? ☐ Yes ☐ No
If yes, please describe:_____

Has there been a change in your child's sleeping habits? ☐ Yes ☐ No
If yes, please describe:_____

Has there been a change in your child's disposition? ☐ Yes ☐ No
If yes, please describe:_____

Does your child cry if a parent attempts to change its sleeping position? ☐ Yes ☐ No

Does your child wake up crying frequently at night? ☐ Yes ☐ No

Are there any other alterations of your child's normal sleep pattern? ☐ Yes ☐ No
If yes, please describe:_____

Does your child have a fever of unknown origin? ☐ Yes ☐ No

Does your child have a loss of appetite or other recent eating disorder? ☐ Yes ☐ No
If yes, please describe:_____

Does your child have a recent change in "bathroom" habits? ☐ Yes ☐ No
If yes, please describe:_____

Has your child recently become irritable, restless, or grumpy? ☐ Yes ☐ No
If yes, please describe:_____

History of Birth

What was the child's gestational age at birth? _____ Weeks.
Birth weight _____lbs._____ oz. _____ Birth length _____inches
Was your child's birth ☐at home ☐in a birthing center ☐in a hospital
Was the birth considered ☐ medical ☐midwife
What was the duration of the labour and birth?_____ hours
Was child born ☐ Cephalic (head first) ☐Breech (feet first)
Were there any complications? ☐ Yes ☐No If yes, please explain _____
_____
Please check any assistance which was used during the birth:
☐ Forceps ☐ Vacuum Extraction ☐ C-Section ☐ Episiotomy
Was labour ☐ Spontaneous ☐ Induced
Were medications or epidurals given to the mother during birth? ☐ Yes ☐ No If yes, what was given? ____
_____
APGAR score: at Birth _____ /10 After 5 minutes _____ /10

Growth and Development

Was the infant alert and responsive within 12 hours of delivery? ☐ Yes ☐ No If no, please explain _____
_____
At what age did the child: Respond to sound _____Follow an object ____ Hold up head _____Vocalize_____
Sit alone_____Teeth_____ Crawl _____Walk _____
Do you consider the child's sleeping pattern normal? ☐ Yes ☐ No If no, please explain_____
_____

Family Health History

Please note any health problems (Eg. Cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:
Mother's family_____
Father's family _____
Sibling(s) _____

In this office we will perform a thorough assessment of your child's spine to locate areas of Vertebral Subluxations. Subluxations are the areas of dysfunction in the spine that interfere with the healthy connection between the nervous system and all the different parts of your body. This will result in compromised health and reduced energy to the tissue which that part of the nervous system supplies. Subluxations are caused by *physical, chemical* and *mental/emotional* stresses that overwhelm the nervous system and spine. Please complete the next page of this form to the best of your ability. This will help us to determine the causes of the subluxations we may find.

Physical Stressors

Any traumas to the mother during pregnancy? (Eg. Falls, accidents, etc.) ☐ Yes ☐No If yes, please explain _____

Any evidence of birth trauma to the infant?

☐ Bruising ☐ Odd Shaped Head ☐ Stuck In Birth Canal
☐ Fast Or Excessively Long Birth ☐ Respiratory Depression ☐ Cord Around Neck

Any falls from couches, beds, change tables, etc? ☐ Yes ☐ No If yes, please explain _____

_____

Any traumas resulting in bruises, cuts, stitches, or fractures? ☐ Yes ☐ No If yes, please explain _____

_____

Any hospitalizations or surgeries? ☐ Yes ☐ No If yes, please explain _____

_____

Any sports played? _____

Is a school backpack used? ☐ Yes ☐ No If yes, is it ☐ Heavy ☐ Light

Chemical Stressors

Was this child breast-fed? ☐ Yes ☐ No If yes, how long? _____

Formula introduced at what age? _____ What formula? _____

Introduction of cow's milk at what age? _____

Began solid foods at what age? _____ Type of foods? _____

Food / Juice intolerance? ☐ Yes ☐ No If yes, what type? _____

During pregnancy, did the mother, smoke? ☐ Yes ☐ No How much? _____

drink? ☐ Yes ☐ No How much? _____

Any illnesses during the pregnancy? ☐ Yes ☐ No If yes, what illnesses? _____

_____

Any supplements taken during pregnancy? ☐ Yes ☐ No If yes, what supplements? _____

_____

Any drugs taken during pregnancy? ☐ Yes ☐ No If yes, what drugs? _____

_____

Any ultrasounds? ☐ Yes ☐ No How many and reasons for being done? _____

_____

Any invasive procedures during pregnancy (Eg. Amniocentesis, CVS, etc.)? ☐ Yes ☐ No Please explain ___

_____

Any pets at home? ☐ Yes ☐ No If yes, what kind(s)? _____

Any smokers in the home? ☐ Yes ☐ No

Vaccination History

Vaccinations and age given? _____

Any negative reactions? ☐ Yes ☐ No If yes, what were they? _____

Any antibiotics given? ☐ Yes ☐ No Reason? _____

Psychosocial Stressors

Any difficulties with lactation? ☐Yes ☐No If yes, what are they? _____

Any problems with bonding? ☐Yes ☐No If yes, what are they? _____

Any behavioural problems? ☐Yes ☐No If yes, what are they? _____

Any ☐ night terrors ☐ sleep walking ☐ difficulty sleeping

Age of child when he/she began daycare? _____

Average number of hours of television per week? _____

Do you feel that your child's social and emotional development is normal for their age? ☐ Yes ☐ No If yes, how? _____

Please Read Carefully:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and / or anyone working in this clinic authorized by the doctor of chiropractic.

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatments. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because strokes sometimes cause serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote

c) There are 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 subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, 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 have had an opportunity to discuss with the doctor of chiropractic / staff member and / or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the Doctor either before or after I sign this consent, and I understand that my consent can be withdrawn at any time.

Dated this _____ day of _____, 20 _____.

_____ _____

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

_____ _____

Print Name **Print Name**

Binbrook Chiropractic & Physiotherapy
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PRIVACY POLICY
PATIENT DISCLOSURE FORM: FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of providing you with quality Physiotherapy care. We understand the importance of protecting your personal information, and are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, Harnek Gill acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Attached to this consent form, we have outlined what your office is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation, standards or our regulatory body, the College of Physiotherapists of Ontario, and the law

Do not hesitate to discuss our policies with any member of our office staff. Please be assured that every staff person in our office is committed to ensure that you receive the best quality care.

PRIVACY POLICY
How Our Office Collects, Uses and Discloses Patients' Personal Information

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

This office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care;
- To identify and to ensure continuous high-quality service;
- To assess your health needs;
- To provide health care;
- To advise your treatment options;
- To enable us to contact you;
- To establish and maintain communication with you;
- To communicate with other treating health-care providers;
- To allow us to efficiently follow-up treatment and care;

- For teaching and demonstrating purposes on an anonymous basis;
- To complete and submit claims for third party adjudication and payment;
- To comply with legal and regulatory requirements, including the delivery of patients' charts and records to the College of Physiotherapists of Ontario in a timely fashion, when required, according to the provisions of the Regulated Health Professionals Act;
- To prepare materials for the Health Profession Appeal and Review Board (HPARB);
- To invoice for goods and services;

- To process credit card payments;
- To comply generally with the law;

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information; we will seek your approval in advance.
Your information may be accessed by the regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purpose of the College of Physiotherapists fulfilling its mandate under the RHPA, and for the defense of a legal issue.
Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of request made, we will forward the information directly to you for review, and for your specific consent.
When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.
You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and that process.

PATIENT CONSENT

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.
I agree that Binbrook Chiropractic & Physiotherapy can collect, use and disclose personal information about me as set out above in the information for Binbrook Family Chiropractic.

_____ _____
Signature Print Name

_____
Date

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CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.
Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercises.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related issues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.
The risks include:

- **Temporary worsening of symptoms:** - Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn, may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may not have symptoms. They may now know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.
  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.
  The consequence of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most sever cases, patient symptoms may include impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as the result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel to the brain where it can interrupt blood flow and cause a stroke. Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.
  Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.
  The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance, and brain function, as well as paralysis or death.

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- **Alternatives** – Alternatives to chiropractic treatment may include consulting with other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.
- **Questions or Concerns** – You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for you care. Inform you chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR.

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment as well as the alternatives to treatment. I hereby consent to the chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____
Signature of patient (or legal guardian) Date:_____ 20____

_____ Date:_____ 20____
Signature of Chiropractor