

## Pediatric Intake Form (2 Years and Under)

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY) Gender: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Name of Parent's/Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ May we leave a message? Yes/No

Parent's Work Phone: \_\_\_\_\_ May we leave a message? Yes/No

Parent's Email: \_\_\_\_\_

May we add you to our seasonal newsletter and calendar of events via email? Yes/No

(Your email will not be shared)

Height (of child): \_\_\_\_\_ Weight (of child): \_\_\_\_\_

Are there any siblings? \_\_\_\_\_ Age (s): \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Who can we thank for your referral? \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

### Family Doctor

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Date of last appt. /physical: \_\_\_\_\_

### Other Health Care Professionals

(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, Massage Therapist)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Professional Designation: \_\_\_\_\_

Address: \_\_\_\_\_

Date of last appt. /physical: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Professional Designation: \_\_\_\_\_

Address: \_\_\_\_\_

Date of last appt. / physical: \_\_\_\_\_

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What complaint/concern brings you in? \_\_\_\_\_

Does your baby appear to be in pain or discomfort? \_\_\_\_\_

How long has your baby been experiencing this? \_\_\_\_\_

Is it getting better, worse or staying the same? \_\_\_\_\_

Was the onset sudden or gradual? \_\_\_\_\_

Have you seen other health professionals regarding this complaint? And if so, whom?  
\_\_\_\_\_

What treatment did they use? \_\_\_\_\_

Has your baby taken any medication for this complaint? Yes  No

Has your baby ever experienced this complaint before? Yes  No

Did they receive any treatment at the time? Yes  No

Has your baby had x-rays in relation to the current complaint? Yes  No

Has your baby ever received chiropractic care previously? Yes  No  If yes, when? \_\_\_\_\_

Has your baby ever received massage therapy previously? Yes  No  If yes, when? \_\_\_\_\_

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**Prenatal History:**

Ultra-sounds during pregnancy: Yes  No

Medications during pregnancy: Yes  No  If yes, please specify: \_\_\_\_\_

Medications during labour/ delivery: Yes  No  If yes, please specify: \_\_\_\_\_

Was Pitocin used to induce/speed up labour: Yes  No  Unknown

Were your membranes ruptured by a medical professional? Yes  No

Was your child at anytime during your pregnancy in an intra-uterine constricting position, such as:

Breech  Transverse  Face/ Brow presentation

Was your delivery vaginal or C-section? \_\_\_\_\_

If it was a C-section, was it planned or emergency? \_\_\_\_\_

If it was vaginal, was the baby presented:  Head  Face  Breech

Were any of the following used during delivery?

Forceps  Vacuum Extraction  Other, please specify: \_\_\_\_\_

Were there any complications during delivery?  Yes  No

If yes, please specify: \_\_\_\_\_

How long was the labour from the first regular contractions to the birth? \_\_\_\_\_ Hour

How long was the second stage (the pushing phase) of the labour? \_\_\_\_\_ Hours

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**Post Natal History**

How many weeks at gestation was the baby at birth? \_\_\_\_\_

Birth Weight: \_\_\_\_\_ lbs      Birth Length: \_\_\_\_\_ Inches

If known, APGAR scores at:    1 minute \_\_\_\_\_/10      5 minutes \_\_\_\_\_/10

- Baby's Crying:**
- Cried Immediately
  - Cried Strongly
  - Cried Weakly
  - Did not cry for \_\_\_\_\_ minutes

- Baby's Color:**
- Pink all over
  - Blue face
  - Blue hands/feet

- Baby's Activity:**
- Arms and legs actively moving
  - Floppy Baby

Was the baby ever administered to Neonatal Intensive Care?    Yes  No

If yes, for how long and why? \_\_\_\_\_

Was any medication given to the baby at birth?    Yes  No

If yes, what medication and why? \_\_\_\_\_

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**Baby Health History**

How many hours does your baby sleep between feedings? Day \_\_\_\_\_ Night \_\_\_\_\_

Does your baby have a preferred sleeping position?    Yes  No  \_\_\_\_\_

Does your baby have any feeding difficulties?    Yes  No

Is your baby currently being breast fed?    Yes  No

If no, how long was the baby breast fed? \_\_\_\_\_ weeks/months  not at all

Does your baby have a one-sided breast preference?    Yes  No

If yes, Left  or Right

Does your baby frequently spit up after feeding?    Yes  No

Does your baby cry often?    Yes  No  Approximately how many hours a day? \_\_\_\_\_

Does your baby pass a lot of intestinal gas?    Yes  No

Does your baby frequently arch his/her head and neck backwards?    Yes  No

Is your baby currently taking any medication?    Yes  No  If yes, please specify: \_\_\_\_\_

Has your baby taken any medications for an extended period of time in the past?    Yes  No

If yes, please specify: \_\_\_\_\_

Is your baby taking any herbal or vitamin supplementation?    Yes  No

If yes, please specify: \_\_\_\_\_

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### Developmental History

- Has your baby ever fallen from any high places? Yes  No
- Has your baby ever been involved in a motor vehicle accident or near miss? Yes  No
- Has your baby been seen on an emergency basis? Yes  No
- Has your baby broken any bones? Yes  No
- Has your baby had any previous hospitalizations? Yes  No
- Has your baby had any previous surgeries? Yes  No
- Have you chosen to vaccinate your child? Yes  No

If yes, which vaccines have they received?

- DTaP-IPV  Diphtheria, Tetanus, Pertussis, Polio
- MMR  Measles, Mumps, Rubella
- Var  Varicella
- HB  Hepatitis B
- Pneu  Pneumococcal
- Inf  Influenza
- Men  Meningococcal

Describe any reactions your child had to any vaccines: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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### Child Health History

Please CHECK anything which is currently causing your baby problems/concern.

Please CIRCLE anything which has been a problem/concern for your baby in the past.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Ear Infections     | <input type="checkbox"/> Chronic Colds  | <input type="checkbox"/> Upper Respiratory Infections |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Sinus Troubles | <input type="checkbox"/> Colic                        |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Recurring Fevers             |
| <input type="checkbox"/> Seizures           | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Food Sensitivities           |
| <input type="checkbox"/> Constipation       | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Skin Irritations             |

Has your baby experienced any of the following illnesses:

- |                                      |   |                                |
|--------------------------------------|---|--------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Rubella     | <input type="checkbox"/> Rubeola        |                                |
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What do you hope to achieve for your baby by coming to Village Wellness?

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Our primary goal is to work towards the resolution of your current condition as quickly as possible through excellent health care and patient education while helping to prevent you from experiencing this condition again.

Do you have any specific concerns about the therapies that we provide?

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We will always give a thorough explanation of what we've found in our history and physical exam; explain the condition we believe you to be suffering from as well as the treatment options available to you, the expected outcome and any risks involved. Always feel free to ask questions at any stage of your treatment. Good communication is an important part of the treatment and prevention process at Village Wellness.

I hereby authorize the health care professionals at Village Wellness, with my prior knowledge, to release to or obtain any health information from my other health care providers as may be required for the management of my case.

I have read and understood the Village Wellness at Appaloosa fee schedule and cancellation policy. I am aware that if insurance claims are being submitted on my behalf that I am responsible for any outstanding balance not covered by my insurance policy.

Name of Child: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/ Guardian Signature: \_\_\_\_\_

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## Village Wellness Fee Schedule and Cancellation Policy

### Chiropractic Services

Initial Chiropractic Exam/Acupuncture/Laser Therapy	\$90
Subsequent Chiropractic	\$50
Subsequent Laser (30 minute treatment)	\$50
Subsequent Acupuncture	\$60
Combination Chiropractic and Laser	\$65
Combination Chiropractic and Acupuncture	\$90

### Children, Students, Seniors

Initial Chiropractic Exam/Acupuncture/Laser Therapy	\$80
Subsequent Chiropractic	\$45
Subsequent Laser (30 minute treatment)	\$45
Subsequent Acupuncture	\$55
Combination Chiropractic and Laser	\$60
Combination Chiropractic and Acupuncture	\$80

### Orthotics

Custom Orthotic Inserts	\$320
Custom Orthotic Shoes	\$420

### Dietician

Initial Nutrition Consultation	\$80
Follow-up Appointment	\$40

### Massage Therapy

30 Minute Massage	\$48 + tax = \$55.20
45 Minute Massage	\$63 + tax = \$72.45
60 Minute Massage	\$78 + tax = \$89.70
90 Minute Massage	\$125 + tax = \$143.75
60 Minute Hot Stone Massage	\$85 + tax = \$97.75
90 Minute Hot Stone Massage	\$130 + tax = \$149.50

### Reflexology

60 Minute Reflexology	\$78 + tax = \$89.70
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### Hours of Operation

#### Chiropractic/Acupuncture/Laser Therapy

Monday 8am- 8pm
Tuesday 10am- 6pm
Wednesday 12pm- 8pm
Thursday 10am- 6pm
Friday 8am-1pm

### Massage Therapy

Monday 11am- 8pm
Tuesday 10am- 6pm
Wednesday 12 pm- 8pm
Thursday 10am- 6pm
Friday 8am- 1pm

- ✓ We ask that you provide a **MINIMUM 24 HOURS** notice cancellation or risk being charged a **\$25 fee for the missed appointment**
- ✓ If you are calling outside business hours then please leave a message and we will be happy to re-schedule your appointment
- ✓ There will be a \$25 per page charge for medical letters written for referrals for massage therapy or orthotics if requested by your insurance company
- ✓ Initial Exam fee includes chiropractic treatment/acupuncture treatment/laser therapy treatment
- ✓ All payments for services are due at the time of the scheduled appointment
- ✓ Receipts will be issued for reimbursement by your insurance company
- ✓ Those clients with Blue Cross (Veterans, National Defence, and RCMP, also included) or Greenshield are eligible for direct billing. If your coverage does not cover 100% of billings you will be responsible for the remaining balance at the time of each visit
- ✓ Children are considered those from infancy to age 17, Students must show valid ID and seniors are those age 65+

I have read, understood and agreed to the above terms and policies

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_