

Welcome to Complete Health!

This form is to provide your doctor with a detailed health history to better manage your case. Please complete the form to the best of your knowledge.

Email/text notifications

Name: _____ Date: _____

E-mail: _____

Under Canada's new Anti-Spam Legislation, we are required to ask you for your consent to contact you via e-mail for appointment reminders and information regarding your wellness.

Do you consent? YES NO _____

Please sign name here

Cancellation Policy

We require **24 hours notice** for cancellation of Chiropractic, Acupuncture, Naturopath and Massage appointments otherwise the full cost of the treatment will be charged to you.

We understand some circumstances are beyond your control, so please discuss with us when cancelling.

No shows will be charged the full treatment amount.

Patient Signature

Child's Personal Information

Date: _____ Alberta Healthcare Number: _____

First Name: _____ Last Name: _____

Parent A Name: _____ Parent A Phone #: _____

Parent B Name: _____ Parent B Phone #: _____

DOB: _____ Age: _____ Male Female Other

Num. of siblings: _____ Child's Weight: _____ Child's Height: _____

Address: _____ City: _____ Postal Code: _____

How did you hear about Complete Health? _____

Has your child ever seen a Chiropractor? YES NO

Who? _____ Date of last adjustment? _____

Pediatrician / Family Medical Doctor: _____

Date of last visit to Medical Doctor: _____ Purpose: _____

Vaccination history: _____

Childhood Diseases: Chickenpox Rubella Mumps Measles Whooping Cough

Other: _____

Reactions to vaccinations: _____

What operations has he/she had? When? _____

Has he/she ever been seen in Emergency? YES NO Why: _____

Has he/she ever been hospitalized? YES NO Why: _____

Has he/she ever had any bad accidents or falls? Yes No If so, when? _____

Broken/Fractured bones? Yes No Which ones? _____

Length of Pregnancy: Full term Early Late

Problems during pregnancy: _____

Location of birth: Home Hospital: _____ Other: _____

Type of birth/delivery: Normal Vaginal Breech Cesarean

Invasive procedures: Epidural Forceps Vacuum

Length of labour: _____

Name of obstetrician/midwife: _____

Birth Weight: _____ lbs / kg Birth Length: _____ cm / mm

Presence at birth: Jaundice (yellow skin color) Cyanosis (blue color) N/A

APGAR scores: _____

Congenital anomalies/defects: _____

Purpose of this appointment: _____

Explain how complaint occurred: _____

When did this condition begin? _____

Condition has persisted for: DAYS WEEKS MONTHS YEARS

What activities make this condition better? _____

What activities make this condition worse? _____

Have you seen anyone else for this condition? If so, whom? _____

Medications/supplements/vitamins you are taking: _____

**Check any of the following conditions that are a problem CURRENTLY
Circle any that were a problem in the PAST.**

- | | | |
|--|--|---|
| <input type="checkbox"/> Sore Muscles | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Sore Joints | <input type="checkbox"/> Allergies | <input type="checkbox"/> Extreme Fussiness |
| <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Screaming/Crying |
| <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Night Terrors |
| <input type="checkbox"/> Muscle Jerking | <input type="checkbox"/> Fainting | <input type="checkbox"/> Tilting Head To One Side |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Earaches/Infections | <input type="checkbox"/> Preferred Side Nursing |
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Difficulty Nursing |
| <input type="checkbox"/> Painful Tailbone | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Slow Weight Gain |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hernias |
| <input type="checkbox"/> Spinal Curvature | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Skin Eruptions/Eczema |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Enlarged Glands | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Difficulty Chewing/Clicking Jaw | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Loss Of Weight |
| <input type="checkbox"/> General Stiffness | <input type="checkbox"/> Poor/Excessive Appetite | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Junk Food | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Feet Turn In/Out | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Coordination Problems | <input type="checkbox"/> Depression/Confusion | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Lack Of Full Head/Neck Movement | |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Fussing When Placed In Specific Positions | |

AUTHORIZATION FOR CARE OF A MINOR

The Informed Consent must disclose, to the patient or the guardian of a minor patient, the nature of the proposed treatment or procedure and any potential risks including those that may be of a special or unusual nature.

I HEREBY AUTHORIZE THIS CLINIC AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY TO MY SON / DAUGHTER / WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

Signed: _____ Date: _____

I understand that Chiropractic does not treat the disease or symptoms but uses them to ascertain where the specific adjustment(s) are needed. Chiropractic only attempts to adjust vertebrae, restoring the nerve impulses to the involved tissue, thus allowing the body it's best chance of healing itself. I give the doctors and assistants at Complete Health Chiropractic and Massage full permission to render care to myself and/or my family.

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