Stibbard Chiropractic
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Pediatric Information Form (Birth-12 Years)

Name: _____ DOB: _____
Gender: Male Female Other: _____

Address: _____
City:_____ Province: _____
Home Phone: _____ Cell Phone: _____
Email: _____

Emergency Contact Name: _____
Phone Number: _____ Relationship: _____

Medical Dr. Name:_____Date of last physical: _____
Previous Chiropractor Name: _____
Permission to Contact above health care providers: Yes No

How did you hear about our clinic?: _____

Private Insurance Provider: _____
Policy #: _____ Member #: _____
Name of card holder: _____
Relationship to card holder: _____

Is this a workplace injury or motor vehicle accident?: _____
Claim Number: _____

Patient Information

Parent(s) Name: _____

What is the primary reason that you are seeking Chiropractic care for your child?

_____

When did this problem begin?_____

Is it getting worse? □ Yes □ No

Is this problem:(circle) 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?____

Prenatal History

Any complications during pregnancy: _____

During pregnancy, did the mother:

Drink alcohol: □ Yes □ No

Use tobacco: □ Yes □ No

Vaccines/medications □ Yes □ No

Reasons for vaccines/medications: _____

Illnesses/infections during pregnancy: _____

Supplements during pregnancy: _____

Ultrasounds or other testing: _____

Birth History

Place of birth: □ Home □ Birthing Center □ Hospital

Provider: □ Midwife □ OB-Gyn □ Other

Type of Birth: □ Vaginal □ Cesarean

Duration of gestation:_____

Were pain medications used?_____

Was labour induced?_____

Birth trauma? □ Doctor Assisted □ Twisting/Pulling □ Vacuum Extraction □ Forceps

APGAR score if known?_____

Did your child have a misshaped skull/head? □ Yes □ No

Did your child have any bruising in the skull/face? □ Yes □ No Where? _____

Has your baby been diagnosed with any heart issues or other medical concerns? _____

Please list all medial diagnosis/ concerns: _____

Did you baby receive a Vitamin K injection at birth? □ Yes □ No

Vitamin K is routinely given to newborns unless you actively refused the treatment

Has your baby previously had a tongue or lip tie release? □ Yes □ No

Have you worked with a lactation consultant outside of the hospital? □ Yes □ No

Growth and Development

Was your infant alert and responsive within twelve hours of delivery? □ Yes □ No

At what age did your child:

Respond to sound: _____Hold up head:_____Begin to teethe: _____Crawl: _____

Follow an object: _____ Vocalize:_____ Sit up unassisted: _____Walk:_____

Has baby had a strong neck since birth? □ Yes □ No

Was baby able to roll to the side in the first weeks of life? □ Yes □ No

Is baby always turning their head to one side? □ Yes □ No L or R (please circle)

Does baby's body seem very tense or rigid □ Yes □ No

Chemical Stressors

Did you breast feed your child? □ Yes □ No How long?_____

Was formula introduced? □ Yes □ No At what age?_____

Began solids at what age? _____Type of first food?_____

List any food allergies?_____

Has your child been vaccinated? □ Yes □ No

Did your child have any reactions to these vaccines? □ Yes □ No

Has your child been on antibiotics? □ Yes □ No

If yes, how often and for what purpose?_____

Is your child currently taking any vitamins? □ Yes □ No

If yes, please list:_____

Please list all medication: _____

Please list any allergies if known:_____

How many glasses does your child drink per day? Water _____Milk _____Juice _____Soda

Does your child consume artificial sweeteners? □ Yes □ No

Rate your child's diet: □ Well-balanced □ Average □ High sugar/processed food

What is your child's favourite food? _____

Health History: Please fill out if age 0-4 years

Have any of the following occurred? Please circle

Jaundice	Anemia	Cyanosis	Seizures
Infections	Tonsilitis	Reflux	Repeated colds
Frequent ear infections	Colic	Frequent diarrhea	Constipation
Sleeping problems	Frequent fevers	Frequent crying spells	
Fall from a changing table	Fall out of crib	Fall off playground	Car accident
Tumble down stairs	Play in jolly jumper	Other: _____	

Health History: Please fill out if age 5-12 years

Have any of the following occurred? Please circle

Fall from a tree	Stomach pains	Bed-wetting	
Fall off a bicycle	Hyperactivity/Autism	Headaches/ migraines	
Fall on playground	Leg/Knee pains	Allergies	
Sports accident	Scoliosis	Growing pains	
Car accident	Learning difficulties	Asthma	Other:_____

Does your child participate in any athletic or extracurricular activities? □ Yes □ No

If yes, which ones?_____

How many hours of sleep does your child get per day?_____

Sleep quality: □ Good □ Fair □ Poor

Is there anything else the Doctor should know? _____

Have you, the child's legal guardian, had any personal experience with Chiropractic? □ Yes □ No

Authorization to Evaluate and Care for a Minor

I, _____, the undersigning parent/guardian having legal custody/guardianship of , a minor, do hereby authorize, request, and direct the staff and doctors of Stibbard Chiropractic Clinic to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Child's Name:_____

Parent/Guardian's Signature: _____Date: _____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Updated: September 2025

CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

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

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about 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. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____
Patient Name (print)

_____	_____	_____
Patient/Guardian Signature	Date	Chiropractor Signature

Accuracy of Information

I certify that the above medical information is correct to my knowledge. _____ **Initial Here**

Privacy & Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medial information as documented above. In addition, I authorize the clinic and its associated health professionals communicate with my family doctor and/ or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. _____ **Initial Here**

Cancellation Policy

Your appointment time is reserved just for youj. A late cancellation of missed visit leaves a hole in the health professionals' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment may be subject to cancellation fee. _____ **Initial Here**

Direct Billing Consent Forms

Benefit Assignment Form

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/ plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider. _____ **Initial Here**

Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and / or plan administrator and their service provider(s) to:

-use my personal information for the above purposes.
-exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
-exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
-exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information for the healthcare provider and the insurer and/ or plan administrator and their service provider(s) to use and disclose their personal information as set out above. _____ **Initial Here**