Dr. Clarise Chan, B.Sc. (Hons), DC

Clarity Wellness Chiropractic

File No. _____

PERSONAL HEALTH PROFILE (CHILD)

All patient information collected is protected by privacy legislation detailed in the Privacy Information Consent forms included with this new patient intake forms package.

CONTACT INFORMATION

Child's First Name: _____ Child's Last Name: _____

Parent / Guardian's First Name _____ Parent / Guardian's Last Name: _____

Home Phone #: _____ Parent's Work / Cell #: _____

How did your child hear about us/Referred by? _____

CHILD'S PERSONAL INFORMATION

Child's Current Age: _____ Child's Birth Date Month: _____ Date: _____ Year: _____

Biological Sex: Male ☐ Female ☐

If you are under the age of majority in Ontario, you will need authorized written parent/guardian authorization for chiropractic care at this clinic.

Parental Consent - By signing this new patient intake form for my child(ren), I am agreeing all information contained herein is accurate to provide the clinic staff and the Chiropractor to understand my child's health and assist through chiropractic care and education. I am also agreeing to allow the clinic to perform an examination, and any necessary testing (i.e. x-rays etc), involved to better understand the child's specific health concerns. I am agreeing the Chiropractor may perform adjustments on my child(ren) based on their individual examination findings and testing.

Parent's Name: _____ Parent's Signature: _____

Date of Signature: _____

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DISCOVERY – YOUR CHILD'S HEALTH HISTORY

SPORTS & RECREATION

Sports Injuries:

DOES YOUR CHILD PARTICIPATE IN ANY OF THESE HIGH IMPACT ACTIVITIES? (please select all applicable):

Hockey ☐ Running ☐ Football ☐ Wrestling ☐ Mountain Biking ☐ (Rock) Climbing ☐

Basketball ☐ Baseball ☐ Gymnastics/Weights ☐ Martial Arts ☐ Winter Sports ☐ Other _____

FALLS AND TRIPS

Falls from heights: Falls down stairs:

Other falls: Broken bones:

Concussions: Home Injuries:

FALLS FROM ☐ Trees ☐ Play structure ☐ Raised platform ☐ Bicycle/Skating Other: _____

POSTURES AND HABITS

Sitting > 6 hours daily ☐ Slouching ☐ Straining forward towards desk ☐ Constantly looking down at phone ☐ Computer Use ☐ Head Forward Posture ☐

Have your family, friends, peers, or others comment about your child's posture? What do they say?

BIRTH TRAUMA

Was your child's birth delivery any of the following (please select applicable)?

Long & Difficult ☐ Forceps ☐ C-Section ☐ Epidural ☐ Suction ☐

Natural (no drugs / pulling / excessive force) ☐ Breech ☐ Induced ☐ Resuscitation ☐

Other Birth Trauma :

Duration of Birth/Labor: Child's Birth Length (inches):

Type of delivery (hospital, home, birthing center, midwife):

Was the infant child alert and responsive within 12 hours of delivery?

CHILD DEVELOPMENT AND FAMILY ENVIRONMENT

Has your child met the developmental milestones at the appropriate times?

How is your child's sleeping pattern ? (usual bed time, blue light from eletronics, nightmares, bed-wetting, frequent bathroom trips)

Any smokers (e-cigarettes, vaping included) in the household where the child is exposed to second hand smoke?

List any health problems (cancer, diabetes, heart diesease etc) on either parent's side of the family or siblings?

CHILD STRESSORS

Please identify any of the problems / issues that your child may be exposed to as these stressors and traumas are key indicators to issues that may be hindering the healthly development of your child.

Chemcial Stressors

Was the baby breast-fed Yes ☐ No ☐

Duration and comments ?

Infancy - any dificulties with lactation, latching, or sucking during breast feeding?

Food intolerances?

Any illness of the mother during pregnancy?

Any supplements mother was taking during pregnancy?

Any vaccinations ?

Any antibiotics or medications?

Psychosocial

Any behavior problems at school, social settings, or in the general public?

Any night terrors, nightmares, sleep walking, difficulty sleeping?

Any signs or has your child indicated issues with school bullying or peer pressure?

Describe your child's interaction and exposure to social media?

Traumatic

Any traumas with bruising, cuts, stitches, fractures?

Any hospitalizations, surgeries, or organs removed?

Any history of ear infections, regular colds, strep throat, croup, pneumonia, or bronchitis?

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4-36 Park Lawn Road | 905-990-5000

PRIVACY INFORMATION CONSENT

Clarity Wellness Chiropractic has always taken our patients' confidentiality seriously. We understand that you entrust us with your personal and medical information. We are committed to take all necessary measures to safeguard this information.

Our privacy policy fully complies with the federal government's Personal Information Protection & Electronic Documents Act (PIPEDA), which sets out guidelines for the collection, use, and disclosure of personal information.

This consent form outlines what we do 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 protocols.

Our 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 and provide care;
* To establish & maintain communication with you;
* To advise you of your treatment options;
* To communicate with other treating health-care providers;
* For teaching & demonstrating purposes on an anonymous basis;
* To process, invoice, and collect payments for goods & services;
* To complete and submit forms for third party adjudication and payment;
* To comply with legal and regulatory requirements including delivery of patient charts/records to governing bodies according to the provisions of the Regulated Health Professions Act/Health Professions Appeal and Review Board;
* To permit potential purchasers, practiced brokers, or advisors to evaluate Practice
* To deliver your charts and records to the office's insurance carrier to enable them to assess liability and quantify damages, if any

Our office will not supply our insurer with confidential medical history. In the event such a request is made, we will notify you. You will also be notified should any other unusual or inappropriate requests be received.

Please read other side….

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PRIVACY INFORMATION CONSENT (CONTINUED)

By signing this consent form, you agree that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes listed. If a new purpose arises, we will seek your approval in advance. You may withdraw your consent at any time. We will explain the ramifications of that decision and process.

I have reviewed the above document that explains how this office will use my personal information and how it will be protected.

I have been informed that the office has a Privacy Code and that I can view it at any time.

I agree that the doctors, and staff of Clarity Wellness Chiropractic may collect, use and disclose personal information as outlined in this document in accordance with the Personal Information Protection and Electronic Documents Act (PIPEDA).

Print Name	Signature/Guardian Signature
Date	Signature of Witness

If you have any questions or concerns regarding our Privacy Policy or our collection use or disclosure of your personal information, please discuss them with or notify us by writing to:

Privacy Officer
Clarity Wellness Chiropractic
36 Park Lawn Road Unit 4
Etobicoke, Ontario M8V 0E5

We appreciate your confidence in us.