Merivale Chiropractic and
Massage Clinic
460 West Hunt Club Road
Ottawa, ON K2E 0B8
613-226-8142
www.merivalechiro.com

MERIVALE CHIROPRACTIC CLINIC

Initial Child & Adolescent Questionnaire

Your Name: _____, Your Mom: _____

Birth Date: _____, Your Dad: _____

Telephone Number: _____

Your Address: _____

City: _____ Prov: _____ Postal Code:_____

Email Address: _____

☐ check this box if we may contact you via email with our monthly newsletter, promotions, contests, and prizes.

Mainly for Moms:

1. Tell us about your pregnancy:

Did you carry to full term? _____

Describe any complications and when they occurred: _____

_____

_____

2. Tell us about your delivery and birth of this child:

Did you use a midwife? _____ Hospital? _____ Obstetrician? _____
Did you have a C-Section? _____ Were forceps used? _____
Vacuum Extraction? _____ Were you induced? _____
Did you have an Epidural? _____ Was it a difficult birth? _____
What was the baby=s **APGAR** Score? _____ at 5 minutes? _____

3. Tell us more:

Did you breastfeed? _____ How long? _____ What formula after? _____
Did you consume alcohol during your pregnancy? _____ How much? _____
Did you smoke? _____ How much? _____ How long? _____
Did you take any medication during your pregnancy? _____
For what? _____ What type? _____

Any exposures to ultrasound?_____, How many?_____

4. As a baby/toddler, (birth to 4 years), did any of the following occur?

___ Fall from a change table
___ Tumble down stairs
___ Fall out of crib
___ Involved in car accident
___ Fall off playground equipment
___ Play in a Jolly Jumper
___ Frequent ear infections
___ Tonsillitis
___ Reaction to vaccination
___ Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Sleeping problems
___ Frequent colds
___ Colic
___ Did not gain weight
___ Other_____

Please explain the above: _____

_____

_____

5. As a young child, (5-12 years), did any of the following occur?

___ Fall from a tree
___ Fall of a bicycle
___ Fall of playground equipment
___ Sports accident
___ Car accident
___ Stomach pains
___ Scoliosis
___ Bed wetting
___ Hyperactivity/Autism
___ Learning difficulties
___ Asthma
___ Allergies
___ Leg/knee pains
___ Other_____

Please explain the above: _____

_____

_____

6. Tell us about any vaccinations your child has had: _____

_____

_____

Any reactions to any of these? _____

_____

Were you told that you had a choice in vaccinating your child? ___**YES**, ___**NO**

7. As a child or adolescent, has your child experienced any of the following:

___ Headaches
___ Dizziness
___ Ringing in ears
___ Asthma
___ Hyperactivity
___ Fatigue
___ Numbness in arms/hands
___ Arm/wrist pains
___ Sleeping problems
___ Allergies
___ Stomach problems
___ Weight gain/loss
___ Foot/ankle/knee pains
___ Tingling in arms/legs
___ Neck/back pains
___ Shoulder pains
___ Growing Pains
___ Other _____

Please explain any of the above: _____

_____

8. Which of the problems you have checked off is the worst? _____

_____ this problem: Constant ___, Intermittent ___, Occasional ___, Cyclic ____

9. How long has it persisted? _____

10. When is it at its worst, how does it make your child feel? _____

11. What have you done about it that has NOT worked? _____

_____

_____

12. What makes it worse? _____

13. What effect does this problem have on your child's body functions?

_____

_____

On his/her participation in daily activities? _____

14. Describe any hospital stays: _____

_____

15. Approximately how many times have antibiotics been prescribed and for what conditions? _____

_____

16. List any medications your child is currently taking: _____

_____

17. To summarize, what is your purpose for this appointment? _____

_____

_____

18. Is there anything else you feel we should know? _____

_____

_____

_____

Signature of parent or guardian: _____

Date: _____

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MERIVALE CHIROPRACTIC CLINIC

Our Fee Structure

Please note our fees for your initial visit:

Consultation	Complimentary
Examination	$150.00
Radiology	$0.00-$84.00 (subsidized by OHIP)
X-Ray Report	$30.00
Adjustment /Visit	$50.00
Modality / Traction	$25.00 (in addition to regular visit fee)
Concussion Screening	$65.00 (in addition to regular visit fee)
Year End Progress Exam	$70.00
Acupuncture with Adjustment	$25.00 (in addition to regular visit fee)
Acupuncture 15 minute	$50.00
30 minute	$60.00
45 minute	$80.00
1 hour	$100.00

Please note that if you have been involved in a motor vehicle accident, our fee structure may differ due to the complexity of your needs in such cases.

Please also note that your clinical Report of Findings, the time that your doctor will spend with you to go over your results, will be included in your initial fee.

I fully understand the above fees and give my consent. I also give my consent to have the doctor take any x-rays he/she deems appropriate to better understand my problem and monitor my progress.

Who is responsible for your bill:

You:____ Spouse:___ Auto Ins.:___ WSIB:___ Extended Health Ins.:_____

SIGNATURE: _____ DATE: _____

(Signature of Parent/Guardian required if patient under age 18)

Thank You!

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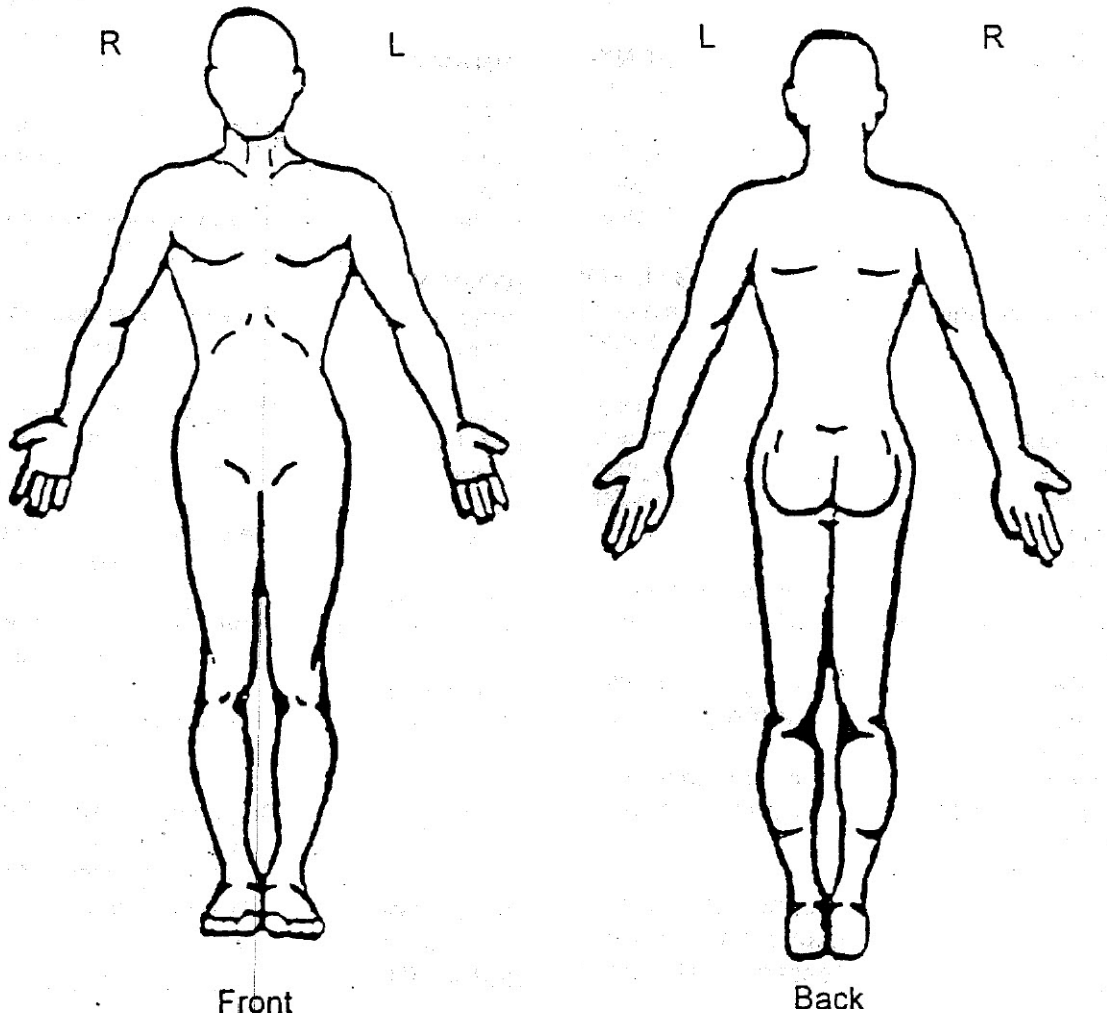
MCC Symptom Diagram

Patient Name:_____ **File #:** _____ **Date:** _____

In the diagrams provided below, please mark the areas on your body, which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below. Also, in order to complete the picture, please draw in your face.

Symbols:

Numbness	≡≡≡	Pins & Needles	⁘⁘⁘
Burning	x x x x x x x x	Stabbing & Sharp	///
Dull & Aching	+ + + + + + + +	Stiff & Tight	2 2 2 2 2 2 2 2



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Health Status Survey

Patient Name: _____ File #: _____ Date: _____

Please circle (**O**) any conditions or symptoms presently causing you problems.
Please check (√) those conditions or symptoms, which have been a problem to you in the past.

GENERAL SYMPTOMS
- ❑ Loss of consciousness
- ❑ Blackouts
- ❑ Headache
- ❑ Fever
- ❑ Sweats
- ❑ Fainting
- ❑ Dizziness
- ❑ Clumsiness
- ❑ Convulsions
- ❑ Loss of sleep
- ❑ Numbness or tingling
- ❑ Pain
- ❑ Nervousness
- ❑ Loss of weight

MUSCLES & JOINTS
- ❑ Stiff neck
- ❑ Backache
- ❑ Swollen joints
- ❑ Painful tailbone
- ❑ Foot trouble
- ❑ Shoulder pain
- ❑ Arm/Forearm pain
- ❑ Elbow pain
- ❑ Wrist pain
- ❑ Hand pain
- ❑ Arthritis
- ❑ Weakness or loss of strength

E.E.N.T.
- ❑ Blurred vision
- ❑ Failing vision (one/both eyes)
- ❑ Crossed eyes
- ❑ Double vision
- ❑ Eye pain
- ❑ Deafness, Earache
- ❑ Ringing, buzzing, any noise in the ears
- ❑ Asthma
- ❑ Frequent colds
- ❑ Sinus infection
- ❑ Enlarged glands
- ❑ Enlarged thyroid
- ❑ Slurred or other speech problems
- ❑ Difficulty swallowing

RESPIRATORY
- ❑ Chronic cough
- ❑ Spitting up phlegm
- ❑ Spitting up blood
- ❑ Chest pain
- ❑ Difficulty breathing

CARDIOVASCULAR
- ❑ Bleeding Disorder
- ❑ High blood pressure
- ❑ Pain over heart
- ❑ Stroke
- ❑ Hardening of arteries
- ❑ Varicose veins
- ❑ Swelling of ankles
- ❑ Poor circulation
- ❑ Heart or blood disease
- ❑ Angina

GENTOURINARY
- ❑ Trouble urinating
- ❑ Blood in urine
- ❑ Kidney infection
- ❑ Bed-wetting
- ❑ Prostate trouble

G.U. FOR WOMEN
- ❑ Painful menstruation
- ❑ Excessive flow
- ❑ Hot flashes
- ❑ Irregular cycle
- ❑ Cramps or backache
- ❑ Vaginal, discharge
- ❑ Swollen breasts
- ❑ Lumps in breasts

Have you ever been on birth control pills? Yes ❑ No ❑

Are you currently taking the birth control pill? Yes ❑ No ❑

# of pregnancies _____
# of children _____

Please inform the doctor if you have ever been tested for HIV or Hepatitis A/B/C.

SKIN
- ❑ Rashes, itching
- ❑ Bruise easily
- ❑ Dryness
- ❑ Boils
- ❑ Hives (allergy)

GASTROINTESTINAL
- ❑ Poor appetite
- ❑ Indigestion
- ❑ Excessive hunger
- ❑ Belching or gas
- ❑ Nausea
- ❑ Vomiting (blood?)
- ❑ Pain over stomach
- ❑ Constipation
- ❑ Diarrhea
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Gall bladder trouble
- ❑ Intestinal worms
- ❑ Ulcer
- ❑ Diabetes

Have you ever had any fractures? Yes ❑ No ❑

Have you ever been in a car accident? Yes ❑ No ❑

Have you ever been hospitalized? Yes ❑ No ❑

If yes, why? _____

Are you currently a smoker? Yes ❑ No ❑

Have you ever smoked in the past? Yes ❑ No ❑

Have you ever been diagnosed with cancer? Yes ❑ No ❑

Do you take medication on a regular basis? Yes ❑ No ❑

If so, what? (blood thinner, blood pressure, etc.) _____

_____