Spine +
469 Bouchard Street, Suite 219
Sudbury, Ontario
P3E 2K8

Tel: 705-988-5080
infospineplus@gmail.com
www.drkassandregoupil.ca

Dr. Kassandre Goupil, DC

CHILD INITIAL INTAKE FORM

Child's Name: _____**Initial Visit Date**:_____

Birthdate: _____ Sex: M / F Ht: _____ Wt: _____Family Doctor: _____

Please list any medications child is currently taking:

_____

Contact Information: *(please check off primary contact person and preferred method(s) of contact)*

Parent/ legal guardian (s) name:_____

☐ Home phone #: _____

☐ Cell phone #: _____

☐ Work phone #: _____

☐ Email Address: _____

Secondary Contact (Name & Phone #):

_____

If more than one residence, please check off which address should be listed for receipts:

☐ Address 1: _____ City: _____ Postal Code: _____

☐ Address 2: _____ City: _____ Postal Code: _____

Can Dr. Kassandre Goupil use your email address to contact you concerning your childs' care? Y/N

How did you hear about this clinic: ☐ Walk by ☐ Website ☐ Flyer

☐ Referral: _____ ☐ Talks/events ☐ Other: _____

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MAIN HEALTH CONCERNS

Please list, in order of importance, your chief concerns:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Family Medical History:

Has anyone in your family had any of the following diseases/conditions?

☐ Hypertension ☐ Heart Disease ☐ Lung Disease ☐ Cancer – type: _____
☐ Stroke ☐ Tuberculosis ☐ Epilepsy ☐ Diabetes
☐ Alzheimer's Disease ☐ Scoliosis ☐ Osteoarthritis ☐ Ankylosing Spondylitis
☐ Multiple Sclerosis ☐ Osteoporosis ☐ Gout ☐ Rheumatoid Arthritis
☐ Psoriasis ☐ Scoliosis ☐ Low Back Pain ☐ Disc Disease
☐ Migraine Headaches ☐ Scarlet Fever ☐ Polio ☐ Diphtheria
☐ Shingles ☐ Alcoholism ☐ Malaria ☐ Anemia
☐ Other (specify):

_____

_____

Pediatric Health Questionnaire

Please complete this questionnaire. Your answers will help us in the complete assessment of your child's spinal health.

Purpose of this office visit: ☐ Spinal Check up ☐ Other(please specify):_____

Please Tell Us About:

Pregnancy - Please check off any applicable conditions/issues:

☐ Toxemia ☐ Diabetes ☐ Pre-Eclampsia ☐ Hypertension ☐ Water Retention

☐ Allergies ☐ Food Sensitivities ☐ Nausea/Vomiting ☐ Heartburn ☐ Back pain

☐ Other:_____

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Delivery/Neonatal Life

Was child Full-term? ☐ Yes ☐ No - # weeks early _____ # weeks late _____
How long was labor? _____ hrs

Were you induced? ☐ Yes ☐ No How? ☐ Vaginal ☐ Intravenous

Any medication used? _____

Please check off all the following that apply:

☐ Episiotomy ☐ Epidural ☐ Vaginal delivery ☐ C-section ☐ Forceps ☐ Vacuum Extraction

☐ Anoxia ☐ Jaundice ☐ Blood Transfusions ☐ Other complications (specify):

Infancy/Childhood

What position does your child sleep in? ☐ Side ☐ Back ☐ Front Has child ever had a postural analysis? ☐ Yes ☐ No Has your child ever been suspected of having/diagnosed with any of the following:

☐ Poor posture ☐ Scoliosis (spinal curvature) ☐ Kyphosis/Lordosis ☐ Hip dysplasia

☐ Leg length inequality ☐ Flat feet ☐ Muscular torticollis

Has child ever been hospitalized? ☐ Yes ☐ No – Reason:

Has child ever had surgery? ☐ Yes ☐ No – Reason:

Has child ever experienced any of the following health problems?

☐ Colic ☐ Allergies ☐ Bronchitis ☐ Pneumonia ☐ Recurrent colds/flu

☐ Food/drug reactions ☐ Asthma ☐ Seizures ☐ Diabetes ☐ Ear infections

☐ Other (specify):

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Has child had any of the following infectious childhood diseases?

☐ Influenza ☐ Mumps ☐ Measles ☐ Poliomyelitis ☐ Chicken Pox

Mononeucleosis ☐ Tuberculosis ☐ Hepatitis ☐ Meningitis ☐ Rubella

☐ Other (specify):

_____

Has child been immunized? ☐ Yes ☐ No
Has child ever had an adverse reaction to vaccines? ☐ Yes ☐ No
Please describe reaction:

_____

Has your child ever had any of the following?

☐ Fracture/dislocation ☐ Concussion ☐ Whiplash ☐ Head trauma ☐ Sports injuries
Please describe:

_____

Has child had any major falls? ☐ Yes ☐ No Describe:

_____

Has child been involved in a car accident? ☐ Yes ☐ No Describe:

_____

Has child had previous chiropractic care? ☐ Yes ☐ No Dr. _____ Reason:

_____

Previous x-rays? ☐ Yes ☐ No Date: _____ Reason:

_____

What is the frequency of child's bowel movements? _____ Consistency? _____

Does child experience discomfort or pain associated with bowel movements? ☐ Yes ☐ No

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Informed Consent and Request for Chiropractic Care

As a patient, I have the right to be informed about my health condition(s) and recommended treatments. Dr. Kassandre Goupil will discuss the potential benefits, risks and alternatives involved. After signing this consent form, I understand I can withdraw consent at any time.

I recognize that even the gentlest therapies may potentially have complications in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs.

I give my written consent for evaluation and treatment. I intend this as a consent form to cover my entire course of treatments including any future conditions for which I seek treatment.

Patient Name	Parent/ Legal Guardian Signature	Date

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Cancellation Policy

Due to the high demand for chiropractic appointments, our office has put into place a cancellation policy that requires **24 hours** of notice. By allowing us 24 hours of notice of your cancellation, we are able to fill that appointment time with a patient in need of treatment.

In the event where you do not give us the 24 hours of notice, the cancellation fee for a chiropractic visit is **$25.00** if the appointment is canceled within 2-24 hours before the scheduled appointment. If the appointment is canceled within an hour before the scheduled appointment or is a "no show" the patient will pay the full fee**.** This fee is non-insurable and must be paid before your next appointment.

It is also important to arrive on time for your appointment. If you arrive late there may be a chance that you will not be able to receive treatment that day.

If you "no show" three consecutive chiropractic appointments with no call, email or other means of contacting our office, you will be officially discharged from Dr.Kass's care. At such time, at your request, Dr.Kass will give you your patient file and facilitate a transfer to another chiropractor.

Print Name:_____

Patient Signature:_____ Date:_____

Chiropractor Signature:_Dr.Kassandre Goupil_____ Date:_____