Guardian Family Chiropractic
127 Church Street
St. Catharines, ON L2R3E2
Ph: 289-273-581

Introduction

Welcome to Guardian Family Chiropractic

Your first visit or reservation at Guardian Family Chiropractic will give us an opportunity to learn about each other. Please take your time to complete to the best of your knowledge the initial intake forms and then submit online. Before you submit please read through consent for examination and chiropractic care, sign at the end electronically using the mouse if using a computer or finger if using an iPad or tablet on the touch screen. We will receive your intake forms electronically, so there is no need to print your documents.

During your first appointment with us, we will go over your current health and review your vital information to give us the information we need. At the same time, you will have the opportunity to interview us about our chiropractic philosophy and technique and tell us about your concerns and wishes.

After completing the initial paperwork, Dr. Cheema will then do a complete analysis of your nervous system. Typically at the end of your first appointment, you will receive your first adjustment if further diagnostic procedures are not needed. If you are new to chiropractic, you will likely have many questions for us. We like to answer your questions about chiropractic, so you are comfortable and at ease. If you are moving to St. Catharines or the Niagara Region and are looking for a new chiropractor, you will likely have questions, as well.

Your first appointment will be all about helping you feel comfortable that you are making an informed decision about your chiropractic care. And, it does not stop with your first appointment, as we are always here to talk to you about your care or care for your family members. We are always happy to answer questions, discuss issues, and find the best path to wellness for you.

Contact

First Name_____ Last Name_____

Address _____

City_____ Prov_____ Postal_____

Gender Male Female Date of Birth _____

Height _____ Weight _____

Parent/Guardian

First Name _____ Last Name _____

Home Phone _____ Cell Phone _____ Email _____

How did you hear about us? Location Patient Physician Advertisement Attorney

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History

Complications during pregnancy? Yes No

Ultrasounds during pregnancy? Yes No

Medications during pregnancy? Yes No

Cigarette/alcohol use during pregnancy? Yes No

Location of Birth: Hospital Home Other

Birth intervention performed: Forceps Vacuum Ex. C-Section None

Delivery Medication? _____

Delivery Complications? Yes No

Birth Weight _____ Birth Length _____ APGAR Scores _____

Breast Fed? Yes No

Formula Yes No

Name of Pediatrician _____ Date of Last Visit _____

Reason for Visit _____ Treatment _____

At what age, in months, was the following introduced?

Solids: _____ Cows's Milk: _____

At what age, in months, was your child able to?

Respond to Sound: _____ Respond to Visual Stimuli: _____ Hold Head Up: _____

Stand Alone: _____ Crawl: _____ Walk Alone: _____

Sit: _____

Personal Illness History ADHD Falling Allergies Asthma Auto Accident Bed Wetting Chronic Colds Colic Constipation Diarrhea Digestive issues Ear Infections Headaches Recurring Fevers Scoliosis Seizures Temper Tantrums Traumat. Birth Vaccine Reaction Other

_____

Vaccination history _____

Family History _____

Please list any vitamins, herbs, or minerals the child takes: _____

Childhood Diseases

Chicken Pox Yes No

_____

Rubeola Yes No

_____

Whooping Cough Yes No

_____

Rubella Yes No

_____

Mumps Yes No

_____

Other Yes No

_____

Childhood Injuries

Fractures Yes No

Auto Accident Yes No

Spinal Injury Yes No

Hospitalization Yes No

Surgery Yes No

Number of doses of antibiotics your child has taken:

Last 6 months:_____ Since birth:_____

Number of doses of other prescription medications your child has taken:

Last 6 months:_____ Since birth:_____

Child's daily habits (skip any questions that do not apply):

Hours of sleep per night (1-24)_____

Child's exercise Heavy Daily Moderate None

Average amount of time spent watching TV, playing video games, or using a computer per day: None 1-3 4-6 7-12 Over 12

How often does this child consume:

Caffeine Drinks: Never Occasionally Daily

Sugar/sweets: Never Occasionally Daily

Dairy Products: Never Occasionally Daily

Wheat Products: Never Occasionally Daily

Fruits/Vegetables: Never Occasionally Daily

Water as a beverage: Never Occasionally Daily

Condition

Present problem:_____ First occurrence of condition:_____

Did something specific cause this condition? (please describe)_____

Since the problem started, is it: Improving Same Worse

Does anything make it better? Yes No

Does anything make it worse? Yes No

Other health professionals seen for this problem (please list name and dates if applicable)

Chiropractor _____

Medical Doctor _____

Other _____

Finalize

Please Read the following carefully before signing.

Consent for Chiropractic Examination

In order to establish a care plan, Dr. Hafiz Cheema must perform an examination and may request other clinical services to determine the exact issues of your complaint(s). I hereby authorize Dr. Hafiz Cheema and whomever he designates to administer a physical examination, or any other clinical service deemed necessary to reach a clinical decision/diagnosis needed to develop an appropriate care plan. I also understand that some procedures or maneuvers may be performed that are intended to reproduce my symptoms and could cause a temporary exacerbation of my symptoms.

Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understands the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives. Chiropractic is a science, philosophy, and art, which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors, we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity. Disturbance or irritation to the nervous system may be caused by vertebral subluxation. A subluxation refers to structural misalignment or fixation between two or more adjacent vertebrae or other joints, causing nerve irritation and resultant alteration in normal

mechanical and neurological functions of the body. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific chiropractic procedure used to eliminate or reduce a subluxation, thereby restoring normal neural transmission to the involved area, and assisting the body?s natural ability to achieve maximum health. Adjustments are done by hand where the doctor will put optimal pressure on the specific segments of the joints. Delay of treatment allows the formation of fibrosis, adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay in treatment will complicate the condition and make future rehabilitation more difficult. If at the beginning or during care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider. All questions regarding the doctor's objective to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. In the practice of chiropractic, there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts known to him or her, to be in my best interest. I have read and fully understand the above statements and therefore accept chiropractic care on this basis. I acknowledge that all the information provided in these forms, including patient demographics, past and present medical history, social and family history is accurate.

*If under the age of 18, please complete on behalf of your child.

**Please sign below before completing.

**After agreeing, please sign and click Submit below.

Relationship to patient _____

Parent/Guardian Signature: