Dr. Jeffrey Gratton

Doctor of Chiropractic

Welcome and congratulations for putting your health first. You have taken a major step towards investing in your health now and for the future. In making your appointment with us you have demonstrated that you are determined and ready to make the essential shifts in your life necessary to experience total health and wellbeing.

My goal as your Chiropractic Doctor is to find the underlying cause(s) of the presenting symptom(s) and formulate a personalized treatment plan that is specific to you. It is important to utilize preventative medicine so to enhance the body`s ability to maintain good health and empower one to make healthy lifestyle choices.

Please take the time to fill out the important form below. The information you provide will greatly assist me to understand what your goals are and what expectations you have so that we can formulate an individualized health care plan tailored to your needs. Any information that is written here or discussed during your Naturopathic visits will be held with the utmost confidentiality. As your Doctor, I am the only person who reviews these forms.

I sincerely thank you for taking this step towards the betterment of your health and I look forward to seeing you at your visit to the clinic.

Yours in Health,
Jeffrey Gratton, DC

Jeffrey Gratton,DC
Chiropractic

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Confidential Pediatric Intake Form

Today's Date:__________________

Last Name: ___________________________ First Name: _________________________ MI: ______
Parent(s): Mother______________Father_____________ Birthdate: _____/_____/_______ Sex: M / F
Mailing Address: _______________________________________ City: _________________________
Province: _________ Postal Code: ________________ Home Phone: _________________
Emergency Contact: __________________________ Relationship to Patient: ________________
Contact's Phone Number: _______________________ Contact's Email: ______________________
Referred to Dr. Jennifer Gratton by: ____

Current Health Care Team:
Patient's Pediatrician: ___________________________ Office Number: _____________
Specialist Physician: ____________________ Specialty:____________ Office Number: _____________
Specialist Physician: _____________________Specialty:____________ Office Number: _____________
Other Health Care Team Members (Ex: massage therapist, nutritionist, acupuncturist, etc.):
Practitioner Name: ________________________________ Office Number: _____________
Practitioner Name: _________________________________ Office Number: _____________

CURRENT HEALTH CONDITION

Please list current health concerns, time of onset, and current treatment:

Condition Onset/Duration Treatment (if any)

____ __________________________
____ __________________________
____ __________________________

PAST MEDICAL HISTORY

Pregnancy: Duration of pregnancy:______________
Any complications with pregnancy?
____
Type of birth delivery (eg. cesarean section, vaginal) Birth Weight:____ lb, Height ____ in.
Any complications with delivery?
____
Newborn: Any significant health concerns as newborn? (e.g. anemia, jaundice, respiratory difficulty, infection)
____

To date, please list history of all major illnesses, hospitalizations, surgical procedures including dates.
____
____
____

History of head injury or other major injury?
____
Has this child ever been unconscious or had seizures?
____

Immunization History (Check all that apply & list months/year of age)

- ☐ MMR
- ☐ DTP
- ☐ Haemophilus influenzae
- ☐ Hep A
- ☐ Hep B
- ☐ Influenza
- ☐ Pneumococcal
- ☐ Polio
- ☐ Tetanus
- ☐ Tetanus booster
- ☐ Smallpox
- ☐ Tuberculin
- ☐ Varicella
- ☐ Other (please list below)

MEDICAL HISTORY

Date of last Physical/Wellness Exam: __________________ Date of last Blood Tests:_______________

Please list any Life Threatening Allergies: ____

Other Allergies, sensitivities, or intolerances (eg. food, medication, environmental, chemical, etc.):

If currently taking any supplements please list brands and dosages of all products you are taking and the reason for taking them: ____
____
____

FAMILY HISTORY

Place appropriate letter(s) in blank if someone in the child's family has/had any of the following. (F=Father, M=Mother, S=Sibling, G=Grandparent)

___ Alcoholism
___ Allergies/Eczema
___ Asthma
___ Autoimmune Disorders
___ Cancer, specify type(s):
 ____
___ Crohn's Disease
___ Diabetes
___ Drug abuse
___ Epilepsy/Seizures
___ Headaches/Migraines
___ Heart Disease
___ Neurological Disorders
___ Obesity
___ Sexually Transmitted
 Infections: _____________
___ Thyroid Disorder
Any other condition:_______________________________

LIFESTYLE:

Please select the following that apply to this child (write N/A if does not apply to child's age)
___ Stays at home ___ Involved in after-school activities (Ex: __________________)
___ Daycare (___ days/week) ___ Socializes well with other children
___ School (grade level______)
___ Holds attention while working on a task

Describe the child's family situation: (number of siblings, parental involvement in child's life, etc):
____
____
____

Breast Fed and/or Bottle Fed (please indicate which one & duration):_____________________________
Any issues with latching?____
History of Projectile vomiting? ____

DIET (If Applicable): Please check any of the following: ___Mixed Diet (animal/vegetable)
___Vegetarian___ Organic Food

Please list any Food Restrictions (e g. dairy, gluten, soy, etc.):
____
____

Any additional information that is important for me to know about your child?
____
____
____

I have completed this form to the best of my ability in reference to this child's health history. I have stated all known health conditions for this child and will alert the practitioner of any new condition as it arises. My signature below indicates that I agree to take full responsibility for bringing this child to chiropractic.
Signature: ____ Date: ____________
Relationship to Patient:____

Informed Consent

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;
b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;
c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has even demonstrated such injures are cause, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of the Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this ____________ day of _________________, 20_____.

____

Patient Signature (Legal Guardian)

Name: ______________________
(please print)

____

Doctor of Chiropractic Signature

Name: ____________________
(please print)