Merivale Chiropracitc &
Massage Clinic
1642 Merivale Road
Merivale Mall
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?_____________________________

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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: ____

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____

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)
Year End Progress Exam	$45.00
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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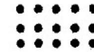
MCC Symptom Diagram

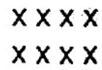
Patient Name:______________________File #: ________________ Date: ___________

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.

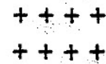
Symbols:

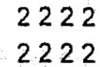
Numbness

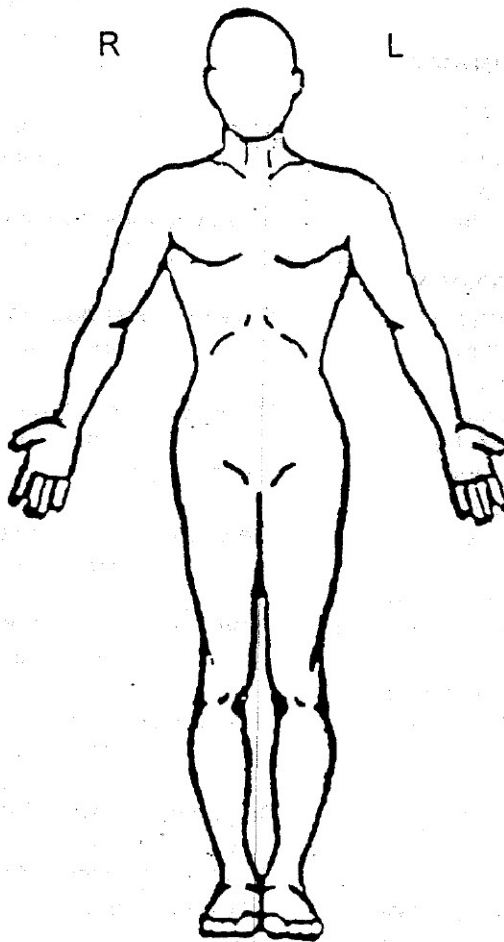
Pins & Needles 

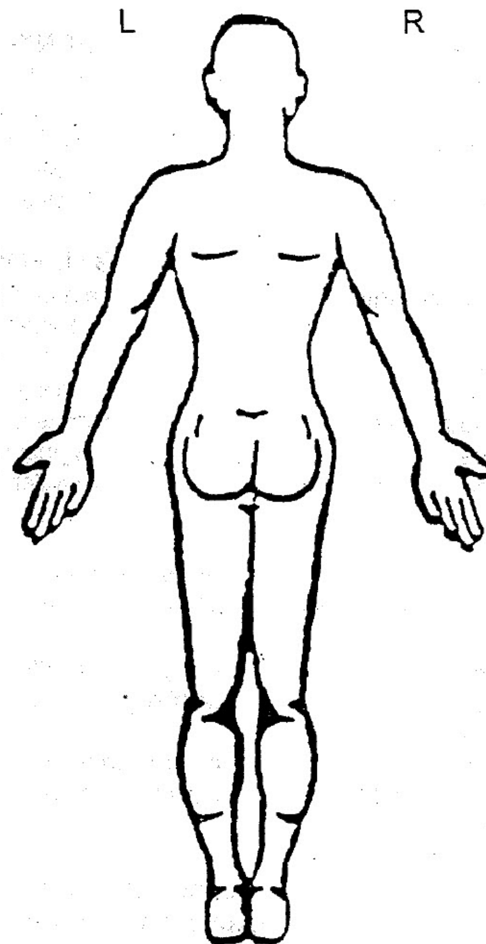
Burning 

Stabbing & Sharp

Dull & Aching 

Stiff & Tight 





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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, pain or tingling
- ❑ 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.)_____________

____

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