

4. HOSPITALIZATIONS, OPERATIONS and ILLNESSES - please list all details and approximate dates:

5. Please list any medication (prescription or over-the-counter) CHILD has taken in the past 6 months and list how often:

6. AUTOMOBILE ACCIDENTS - has your CHILD, even as a passenger, been involved in a car accident or near collision? (even if you think you they not hurt) Yes No

If you answered **YES to question 6**, please complete the following:

Accident Date: _____	Accident Date: _____
Description of Accident: _____	Description of Accident: _____
_____	_____
Speed of Collision _____	Speed of Collision _____
Severity of Damage: _____	Severity of Damage: _____
Injury after Accident: _____	Injury after Accident: _____
Who Examined You: _____	Who Examined You: _____
X-Rays Taken: _____	X-Rays Taken: _____
Did you see a Chiropractor? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did you see a Chiropractor?

7. Primary Daily Activities - constant poor posture will lead to spinal stress and subluxations.

<input type="checkbox"/> Sitting _____ hours per day	<input type="checkbox"/> Computer _____ hours per day
<input type="checkbox"/> Standing _____ hours per day	<input type="checkbox"/> Video Games _____ hours per day
<input type="checkbox"/> Walking _____ hours per day	<input type="checkbox"/> Other _____

Thanks! Please turn over the page.

About Your Health ...

The human body is designed to be healthy. Throughout life, events occur which damage your expression of health . This case history will uncover the layers of damage, especially to your nervous system, that have resulted in your lowered state of health. At your report of findings your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate or inborn health potential.

PRESENT HEALTH: Are you CURRENTLY affected by any of the following ? (please CIRCLE)

MUSCLE and JOINT	GENERAL SYMPTOMS	GASTROINTESTINAL	CARDIOVASCULAR	STRESS SYMPTOMS
Backache Neck pain Foot trouble Shoulder pain Hernia Spinal curvature Poor posture Arthritis	Fever / Chills / Sweats Fainting Convulsions Allergy Skin problems Colds Tremors Loss of balance	Difficult digestion Belching or gas Nausea or vomiting Stomach pain / heartburn Constipation Colon trouble Liver trouble Gall Bladder trouble Diarrhea Bloody stools	Rapid heart beat Slow heart beat High blood pressure Low blood pressure Chest pain Swelling of ankles Poor circulation	Headache / Migraine Dizziness Numbness / pins & needles Ringing in ears Loss of sleep Poor concentration Irritable / Nervousness Depression Decreased energy / fatigue Tension
RESPIRATORY	URINARY	E.E.N.T.	FEMALE ISSUES	
Chronic cough Spitting up phlegm / blood Chest pain Difficulty breathing	Painful urination Waking up at night - urinate Blood in urine Increased urination	Deafness Earache Sore throat Asthma Tonsillitis Sinus trouble	Painful menstruation Excessive flow Irregular menstruation Cramps or backache Abnormal discharge Date of last menstrual period: _____	Post menopause Birth Control Pill Number of miscarriages

PAST HEALTH: Have you ever suffered from any of the following IN THE PAST ? (please CIRCLE)

Thyroid trouble Diabetes Tuberculosis Pneumonia Stomach ulcers Previous heart attack	Emotional problems Epileptic seizures Asthma Alcoholism Psoriasis Previous stroke	Polio Cancer Venereal Disease AIDS / HIV Other: _____
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INFORMED CONSENT TO CHIROPRACTIC CARE, OFFICE POLICIES and AUTHORIZATION

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and, if necessary, diagnostic x-rays on me by Dr. Peter Hryciuk or anyone working in this clinic authorized by him. I have had the opportunity to discuss with the chiropractor the nature and purpose of chiropractic adjustments and other procedures. I understand as in all health care that results are not guaranteed. I further understand and am informed that in the practice of chiropractic, as in all health care, there are some extremely rare risks to treatment, including, but not limited to; muscle strains, sprains, disc injury and stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on his ability to exercise judgement during the course of the procedure which he feels at the time, based on the facts known, is in my best interest.

All outstanding balances are to be settled at the end of each week. In the event you would like to sign out any x-rays the fee is \$40. Chiropractic key fobs are the property of RYCC and the replacement cost is \$25.

Missed appointments (no shows) are subject to a charge. I have read the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above mentioned chiropractic procedures. I intend this consent form to cover the entire course of treatment for any of the conditions which I may have.

By signing below as parent or legal guardian, I am authorizing Dr. Peter Hryciuk or anyone working in this office authorized by him, to provide necessary chiropractic care including history, x-rays, adjustments and any other diagnostic procedure(s) for my child and/or children under the age of eighteen (18).

TO BE COMPLETED BY PARENT or LEGAL GUARDIAN:

PATIENT NAME

SIGNATURE (Patient or Guardian)

DATE