Child Patient (5 – 12 years)

UMINA CHIROPRACTIC CENTRE

N.B. Your information is handled in line with the current privacy regulations

Date: _____

Surname:		**Date of Birth:**	
Given name / s:			**Age:**
Parent's names:			
Residential Address: **Postcode:**			
School name and address: **Permission to contact:** □ Yes □ No			
GP name and address: **Permission to contact your GP?** □ Yes □ No			
Home Phone:	**Mobile Phone:**	**School Phone:**	**G.P Phone:**
Private Health Fund:			
Have you ever received chiropractic care? Yes □ No □ - If so, where and when was the last visit?			

Names of siblings and have they received chiropractic care?	_____ **D.O.B** _____ **Age:** _____	□ Yes □ No
	_____ **D.O.B** _____ **Age:** _____	□ Yes □ No
	_____ **D.O.B** _____ **Age:** _____	□ Yes □ No
	_____ **D.O.B** _____ **Age:** _____	□ Yes □ No

Who may we thank for referring you?	**Have you viewed our website:** www.uminachiropractic.com.au	□ Yes □ No

As a courtesy we endeavor to send SMS reminders the day before your appointment, however, please note it is still your responsibility to be aware of your appointment date and time. If this is not appropriate for you, please advise reception. For information on our cancellation policy, please speak to reception staff.

Today my child is attending for…

□ Maximising normal growth and development through wellness care

□ Symptomatic care (Neck Pain / Back Pain, etc.)

□ Other

_____

_____

CURRENT HEALTH CONCERNS

What concerns do you have regarding your child's health?

_____

_____

_____

Does this concern interfere with any of the following?

□ Sleep □ Eating □ Daily Routine □ Sports □ Other _____

Please Tick the following conditions your child has had or has now ***(tick and please write approx. year)***

Please write the year / s on the line provided			
☐ lower back pain _____	☐ depression _____	☐ behavioral problems _____	☐ bedwetting _____
☐ mid – back pain _____	☐ constipation _____	☐ uncoordinated / clumsy _____	☐ recurrent chest infection _____
☐ neck pain _____	☐ diarrhea _____	☐ reflux _____	☐ recurrent tonsillitis _____
☐ joint problems _____	☐ hyperactivity _____	☐ recurrent cold / flu _____	☐ convulsions _____
☐ scoliosis _____	☐ attention difficulties _____	☐ asthma _____	☐ learning difficulties _____
☐ growing pains _____	☐ social problems _____	☐ allergies _____	☐ fevers _____
☐ headaches _____	☐ ear aches / infections _____	☐ poor appetite _____	☐ adenoid problems _____
☐ dizziness _____	☐ concentration problems _____	☐ chronic fatigue _____	☐ other _____
☐ irritability _____			
☐ dental problems _____			
☐ fatigue _____			

Prenatal History

Did you experience a happy, healthy and supportive pregnancy? □ Yes □ No

If no, please explain why: _____

_____

_____

Was your birthing experience free of complications? □ Yes □ No

If no, please explain why: _____

_____

_____

About the Birth (if known)

Duration of Labour: _____ hours

Were medications or epidurals given to the mother during labour? □ Yes □ No

What type? □ Nitrous oxide gas □ Pethidine □ epidural □ Other _____

At birth, what was the childs:

Birth weight: _____ (gr / Lbs:Oz)

Head circumference: _____ (cm)

Length: _____ (cm)

Apgar Score:

At birth: _____ / 10

After 5 minutes: _____ / 10

Was your child breastfed? Yes □ No □

If yes, how long for: _____

Is there anything else we need to know about the birth? (eg. Head shape or other concerns)

_____

_____

Post Natal History

Has your child had any significant illnesses? □ Yes □ No

If so, what illness /s and when / how long for: _____

_____

Is your child on, or have they been on any medications? □ Yes □ No

If so, what medication / s and how long for: _____

_____

Has your child been hospitalised or had any surgery? □ Yes □ No

If so, what surgery and how long was the hospitalisation: _____

_____

Does your child suffer from allergies / intolerances / sensitivities? □ Yes □ No

If so, what are these: _____

_____

Did your child have any anomalies after birth? (eg. Hip issues, flattening of skull, birthmarks, etc.)

□ Yes □ No – If so, what were they, is there any ongoing issue / s now: _____

_____

Is your child vaccinated? □ Yes □ No

If yes, are their vaccinations up to date? □ Yes □ No

Chemical Stressors

At what age was the following introduced?

Formula _____

Cow's milk _____

Solids _____

What foods were introduced first: _____

_____

Are you aware of the impact of nutrition on children's behavior? □ Yes □ No

How often does your child receive dairy, processed foods, white sugar and gluten in their diet?

□ never □ rarely □ on weekends □ a few times per week □ daily □ nearly each meal

□ Other _____

Psychosocial Health

Has your child experienced any of the following? Please also write approx. year:

Please write the year / s on the line provided

□ Any problems bonding? _____

□ Any behavioral problems? _____

□ Any hyperactivity or restlessness? _____

□ Any difficulties at day care or school? _____

□ Any night terrors / sleep walking / difficulty sleeping? _____

□ Any bedwetting? _____

□ Prolonged temper tantrums or separation anxiety? _____

□ Do you feel that your child's social and emotional development is normal for their age?

_____

Family Health History

Please note any health problems that are present in the family (eg. Cancer, diabetes, heart conditions, respiratory conditions, scoliosis, gut issues, allergies, etc.)

Mother's Family: _____

Father's Family: _____

Siblings: _____

INFORMED CONSENT TO CHIROPRACTIC CARE

Chiropractic care is recognized as being an effective and safe method of care for many conditions. However, changes to the law now require all chiropractors to warn people of material risks.

As in all health care, there are some risks with chiropractic care. This includes, but is not limited to:

Your condition becoming worse;

- Disc injuries, rib fracture, sprains/strains (1 in 139,000 in the neck and 1 in 62,000 in the low back);
- Stroke or stroke like symptoms (1 in 5.85 million neck adjustments)
- Put in context, chiropractic has been shown to be 250 times safer than anti-inflammatory drugs and safer than driving a car.

Some people may experience some mild soreness for 24-48 hours after their adjustments, especially when their body is unwinding. This is a normal sign of change, as may occur after exercise or stretching.

Clinical experience consistently demonstrates ***unexpected improvement*** in people's life. One study indicated that 23% of people experience improvement in some other aspect of their health. Of individuals who experience such improvements:

- 26% experienced improvements in their respiratory system;
- 25% in their digestive system
- 14%circulatory system/heart;
- 14%eyes/vision.

Paediatric Chiropractic Care. I agree to the Chiropractors at the Umina Chiropractic Centre delivering chiropractic care to minors under my care at my instruction. I understand that these chiropractors are not paediatricians; but are qualified to manage chiropractic care in children. I am also aware that these same chiropractors are members of the Chiropractors Association of Australia and are registered health care practitioners under the AHPRA (Australian Health Practitioners Regulatory Authority). The practitioners maintain their competencies by continuing professional development.

Consent to Chiropractic Care. I do not expect the chiropractor to be able to anticipate or explain **all** the risks and complications. I wish to rely on the chiropractor to exercise his/her judgement during the course of procedures which he/she feels at the time, based upon the information known, is in my best interests.

I understand that the intent of chiropractic care is to assist me in achieving my fullest potential. I also understand that maintenance or wellness care does not rely on the presence of symptoms for its application and monitoring and I have, to the best of my knowledge, provided, the chiropractor with a complete and accurate health history. I have read the above consent. I have had the opportunity to discuss with the chiropractor the nature and purpose of chiropractic adjustments and other procedures as well as other concerns. I understand that results are not guaranteed. I intend this consent form to cover the entire course of my chiropractic care for this and any future presentation.

I hereby request and consent to chiropractic examinations, adjustments and other chiropractic procedures wherever the chiropractor determines necessary. By signing below I agree to chiropractic care.

Signature of Patient:_____ **Print Patients name here:**_____
(or Parent/Guardian if under 18)

Parent/Guardian's name:_____ **Date:**_____

Chiropractor's Signature:_____**Date:**_____