

Female Teenage Patient Form (13 – 18 years)



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: <input type="checkbox"/> Yes <input type="checkbox"/> No			
GP name and address:			
Permission to contact your GP? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<u>Home Phone:</u>	<u>Mobile Phone:</u>	<u>School Phone:</u>	<u>G.P Phone:</u>
Private Health Fund:			
Have you ever received chiropractic care? Yes <input type="checkbox"/> No <input type="checkbox"/> - If so, where and when was the last visit?			
Names of siblings and have they received chiropractic care?	_____	D.O.B _____	Age: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
	_____	D.O.B _____	Age: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
	_____	D.O.B _____	Age: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
	_____	D.O.B _____	Age: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Who may we thank for referring you?		Have you viewed our website: www.uminachiropractic.com.au	<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____

Heath History

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			
<input type="checkbox"/> lower back pain _____	<input type="checkbox"/> depression _____	<input type="checkbox"/> behavioral problems _____	<input type="checkbox"/> bedwetting _____
<input type="checkbox"/> mid – back pain _____	<input type="checkbox"/> constipation _____	<input type="checkbox"/> uncoordinated / clumsy _____	<input type="checkbox"/> recurrent chest infection _____
<input type="checkbox"/> neck pain _____	<input type="checkbox"/> diarrhea _____	<input type="checkbox"/> reflux _____	<input type="checkbox"/> recurrent tonsillitis _____
<input type="checkbox"/> joint problems _____	<input type="checkbox"/> hyperactivity _____	<input type="checkbox"/> recurrent cold / flu _____	<input type="checkbox"/> convulsions _____
<input type="checkbox"/> scoliosis _____	<input type="checkbox"/> attention difficulties _____	<input type="checkbox"/> asthma _____	<input type="checkbox"/> learning difficulties _____
<input type="checkbox"/> growing pains _____	<input type="checkbox"/> social problems _____	<input type="checkbox"/> allergies _____	<input type="checkbox"/> fevers _____
<input type="checkbox"/> headaches _____	<input type="checkbox"/> ear aches / infections _____	<input type="checkbox"/> poor appetite _____	<input type="checkbox"/> adenoid problems _____
<input type="checkbox"/> dizziness _____	<input type="checkbox"/> concentration problems _____	<input type="checkbox"/> chronic fatigue _____	<input type="checkbox"/> other _____
<input type="checkbox"/> irritability _____	<input type="checkbox"/> Vaccinations up to date _____	<input type="checkbox"/> Ongoing 'burping' or 'flatulence' _____	
<input type="checkbox"/> dental problems _____			
<input type="checkbox"/> fatigue _____			

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

Please write the year / s on the line provided
<input type="checkbox"/> Any behavioral / hyperactivity problems? _____
<input type="checkbox"/> Any difficulties at school? _____
<input type="checkbox"/> Any night terrors / sleep walking / difficulty sleeping? _____
<input type="checkbox"/> Any concerns about your weight? _____
<input type="checkbox"/> Any concerns about your appearance? _____
<input type="checkbox"/> Are you aware of the impact of nutrition on behavior? _____
<input type="checkbox"/> How often do you eat dairy, processed foods, white sugar and gluten? _____

Have you started menstruating? Yes No

How old were you when you started? _____

How often do you menstruate? _____

Medical History

Medications / Supplements	Dosage:	How Often:	How long have you been taking it for:

NB: If you have a copy of your medication list, please hand to reception on arrival or please list your medications and / or any supplements above.

<u>Accidents / Injuries / Falls</u>	When and how often:
<u>Illnesses</u>	
<u>Surgeries / Hospitalisation</u>	

Did you know that poor water consumption is commonly associated with a significant increase in pain?

Quantity

- Alcohol** Yes No _____per week
- Tea** Yes No _____per day
- Coffee** Yes No _____per day
- Water** Yes No _____per day
- Soft Drink** Yes No _____per day
- Smoke** Yes No Previously _____per day
- Recreational drugs** Yes No Previously

If yes, what sort and when _____

LIFESTYLE CONCERNS

Please fill in the information below so that your Chiropractor can assess the accumulation of stressors on the body that affects your health and ability to heal.

On a scale of 1-10 please rate your:

Eating Habits:

0 1 2 3 4 5 6 7 8 9 10
Poor Excellent

Movement Habits (Eg. exercise, exercising posture & sport)

0 1 2 3 4 5 6 7 8 9 10
Poor Excellent

Sleeping Habits

0 1 2 3 4 5 6 7 8 9 10
Poor Excellent

Home Life

0 1 2 3 4 5 6 7 8 9 10
Poor Excellent

School

0 1 2 3 4 5 6 7 8 9 10
Poor Excellent

Happiness

0 1 2 3 4 5 6 7 8 9 10
Poor Excellent

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: _____