

Please read the following sections carefully and write your answer / tick where appropriate.

PATIENT DETAILS

Child's Name: _____ M / F Date of Birth: ___/___/___ Age: ___
 Parent / Guardian's Name: _____
 Address: _____
 City: _____ State: _____ Postcode: _____
 Telephone (Home): _____ (Mobile): _____ (Work): _____
 Email: _____
 Name of Paediatrician / Doctor: _____ Telephone: _____

Is your family a member of a Private Health Fund that covers Chiropractic Care? YES NO
 Name of your Fund: _____
 Who referred you to this Chiropractic Office? _____

Current concern with your child: _____

PRE-NATAL HISTORY (CONCEPTION to BIRTH)

While pregnant, did the mother:
 Smoke / or Drink Alcohol during Pregnancy? YES NO List: _____
 Take any Medications during Pregnancy? YES NO List: _____
 Have Illness / Complications during Pregnancy ? YES NO List: _____
 Have any falls / traumas during Pregnancy? YES NO List: _____
 Have Ultrasounds During Pregnancy ? YES NO Number: _____
 Duration of Pregnancy in weeks: _____ Age of Mother at time of Birth: _____

PERI-NATAL HISTORY (BIRTH)

Place of Birth: Hospital Birthing Centre Home
 Provider: Midwife Medical Doctor Other
 Child's Birth Weight: _____ APGAR Scores: @1min _____ @5min _____ Unsure
 Type of Birth: Natural Emergency Caesarean Section Planned Caesarean Section
 If not Caesarean Section, was other birth intervention required? Forceps Extraction Vacuum Extraction
 Use of Drugs during birth? YES NO Was the labour chemically induced? YES NO
 Complications during Delivery? YES NO List: _____
 Genetic Disorders or Disabilities: YES NO List: _____

NEO-NATAL HISTORY

Immediately after Birth/During Infancy, did any of the following occur?
 Need for child to be Respirated? YES NO Need for child to be in a humidicrib? YES NO
 Administered medications? YES NO List: _____
 Recent illness? YES NO Surgery? YES NO
 Difficulty Feeding / Latching / Sucking? YES NO
 Breast Fed: YES NO How Long: _____
 Formula Fed: YES NO How Long: _____ Type: _____
 Introduced to Solids at: _____ months, and Cows' milk at _____ months
 Failure to grow/gain weight? YES NO Disrupted sleep patterns? YES NO
 Hours of sleep per night: _____ Number of naps in day: _____ Length of naps in day _____
 Speech or Language difficulties? YES NO

OTHER DEVELOPMENTAL HISTORY

Was your child delayed at any of the following?
 Respond to Sound YES NO Respond to Visual Stimuli YES NO
 Hold Head Up YES NO Sit Up YES NO Crawling YES NO
 Stand Alone YES NO Walk Alone YES NO

Has your child fallen from a height? (eg bed, changing table, down stairs)? YES NO List: _____

Other Falls onto head? YES NO List: _____

Has Your Child Ever Been Involved in a Car Accident? YES NO List: _____

Has your child ever had any broken bones or sprain injuries? YES NO List: _____

Has your child been involved in high impact or contact type sports (eg, Soccer, Football, Gymnastics, Cricket, Martial Arts)? YES NO
List: _____

Has Your Child Been Seen on an Emergency Basis or hospitalised? YES NO List: _____

Is your child currently taking medication of any kind? YES NO List: _____

If you could improve one aspect of your child's health, what would it be? _____

MEDICAL HISTORY:

Has your child experienced any of the following:

- | | | | |
|---|---|---|---|
| <input type="radio"/> ADHD/ADD | <input type="radio"/> Allergies | <input type="radio"/> Anxiety/Depression | <input type="radio"/> Autism/Asperger's |
| <input type="radio"/> Asthma/Bronchitis | <input type="radio"/> Breathing problems | <input type="radio"/> Back / Neck Pain | <input type="radio"/> Bed Wetting |
| <input type="radio"/> Blood Noses | <input type="radio"/> Constipation | <input type="radio"/> Colic | <input type="radio"/> Convulsions/seizures/epilepsy |
| <input type="radio"/> Coughs/Colds | <input type="radio"/> Developmental Delay | <input type="radio"/> Diarrhoea | <input type="radio"/> Difficult Urination |
| <input type="radio"/> Difficulty Swallowing | <input type="radio"/> Digestive Troubles | <input type="radio"/> Ear Ache/Infections | <input type="radio"/> Ear Infections – 2+ |
| <input type="radio"/> Fatigue | <input type="radio"/> Failure to Thrive | <input type="radio"/> Fall - crib/change table | <input type="radio"/> Fall from play equipment/bike/tree etc. |
| <input type="radio"/> Flaking Scalp | <input type="radio"/> Gas | <input type="radio"/> Hyperactivity | <input type="radio"/> Headache |
| <input type="radio"/> Hearing Loss | <input type="radio"/> Irritability | <input type="radio"/> Meningitis | <input type="radio"/> Milk / Lactose Intolerance |
| <input type="radio"/> Muscle Tone Problems | <input type="radio"/> Night Pain | <input type="radio"/> Poor / Excess Weight Gain | <input type="radio"/> Rashes |
| <input type="radio"/> Reflux | <input type="radio"/> Sinus/Allergies | <input type="radio"/> Skin Rashes | <input type="radio"/> Sleep Issues |
| <input type="radio"/> Stomach Pains | <input type="radio"/> Toe Walking | <input type="radio"/> Unusual Movements | <input type="radio"/> Vision Loss |

For Girls, onset of Menarche (first period): YES NO Age: _____

CHILDHOOD DISEASES

- | | | |
|---|--|--|
| <input type="radio"/> Chicken Pox @ Age ____ | <input type="radio"/> Mumps @ Age ____ | <input type="radio"/> Rubella @ Age ____ |
| <input type="radio"/> Whooping Cough @ Age ____ | <input type="radio"/> Measles @ Age ____ | <input type="radio"/> Other (List: _____) @ Age ____ |

CHIROPRACTIC HISTORY

Has your child had previous Chiropractic care? YES NO

If Yes, what is the name of your previous Chiropractor? _____

Where are / were they located? _____

When was the last visit / treatment? _____

Were X-Rays taken? YES NO If Yes, when? _____

Was the previous Chiropractor a Gonstead practitioner? YES NO NOT SURE

What were the results of your previous treatment?

Excellent Satisfactory Fair Did Not Help Got Worse

Parental/Guardian Consent for Examination and Treatment of a Minor

I authorise for my child to be appropriately examined and treated for their condition. I understand that there are minor risks associated with Chiropractic Manipulation and that these risks are minimised by a thorough examination and the utilisation of the Gonstead System of Chiropractic. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and agree to pay the fees which have been explained to me at the time this service is rendered.

_____/_____/_____
 Child / Patient Name (Printed) Parent / Guardian Signature Date

Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks associated with all health care procedures which you should be informed about.

Please read the following carefully

1. I acknowledge that I have discussed with my Chiropractor, the rare risks associated with my proposed care which include but are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries including disc encroachments/ruptures, causing nerve irritation and referred symptoms, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition. Such risks may result in outcomes such as referral, further tests, surgery, incapacity and the like. *In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (current statistics eg between 1 in 2 million to 1 in 5.85 million -Haldeman, et al. Spine vol 24-8 1999). Other possible risks include strain/injury to a ligament or a disc in the neck (current statistics eg less than 1 in 139,000) and the low back (current statistics eg 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible."*
2. I also acknowledge the following additional potential risks insofar as my proposed care is concerned have been explained to me.

Details: _____

3. I have had the opportunity to discuss the proposed care with my Chiropractor. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed Chiropractic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.
4. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.
5. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
6. I hereby acknowledge my consent to the performance of the proposed Chiropractic care by my Chiropractor and/or any other Chiropractor working in this clinic. I understand that I can withdraw consent at any time.
7. I give this clinic permission to use my postal address to send me birthday cards and thank you cards. I also give permission for my children who are under Chiropractic care to have their photograph displayed in this clinic, if the child desires.

Patient Name (Printed)

Patient Signature

(Parent or Guardian must sign if patient under 18years of age)

Chiropractor Name (Witness)

Chiropractor Signature

___ / ___ / _____
Date

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