Confidential
Patient Information

CHIRO4FAMILY WELLNESS
Family Healthcare ... Naturally.

Personal Information Children *0-5 YEARS*

Dear Parent,

Please complete the following questionnaire. Your answers will help us to determine whether chiropractic can help your child. Please note this is a postural and spinal examination only. If treatment is required you will be advised of this.

Thank You

Name of Child _____D.O.B._____/_____/____ Age _____

Parents Names: Father _____

Mother _____

Address: _____

_____

Home Phone_____ Mobile _____Work _____

Email_____

Other Children's Names:

_____ D.O.B._____/_____/_____ Age_____

_____ D.O.B._____/_____/_____ Age_____

_____ D.O.B._____/_____/_____ Age_____

How did you hear of the postural and spinal examination offered in this clinic? (please circle)

Staff Member / Work Shop / Friend / Family / Sign in Reception / Advertisement / Other

Do you have private insurance for chiropractic? YES / NO / Unsure

What concerns do you have regarding the health of your child?

_____

_____

_____

BIRTH

The birth of your child can give vital clues as to potential spinal problems. Please answer the following questions very carefully.

How was your baby delivered:

Normally	Yes / No	Breech	Yes / No	Posterior	Yes / No
Premature	Yes / No	At Term	Yes / No	Caesarian	Yes / No
Late	Yes / No	Forceps	Yes / No	Suction/Vacuum	Yes / No

Other _____

Birth weight_____

How long were you in labour? _____Hours

How long did you 'push' for? _____Mins/hours

Do you feel that the delivery was difficult or traumatic to your baby? Yes / No

Was your baby's head mis-shapen at birth? Yes / No

Were there any delivery complications? Yes / No

Details

_____

_____

BIRTH TO SIX MONTHS

Was your child breast fed? Yes / No For how long? _____

Was your child formula fed? Yes / No For how long? _____

Did your child suffer with colic? Yes / No If yes, how bad was it? Mild □ Moderate □ Severe □

Did your child suffer with reflux? Yes / No If yes, how bad was it? Mild □ Moderate □ Severe □

Would you say your child was a:

□ Very poor sleeper □ Poor sleeper □ Average sleeper

□ Good sleeper □ Very good sleeper

OTHER PROBLEMS

Please indicate by ticking any of the following conditions which your child has experienced in the past:

□ Headache	□ Allergies	□ Neck Pain
□ Back Pain	□ Constipation/Diarrhea	□ Ear aches/Infections
□ Sinus Pain	□ Recurrent Tonsillitis	□ Bedwetting
□ Recurrent chest Infections	□ Growing Pains	□ Hyperactivity
□ Loss of appetite	□ Poor sleeping habits	□ Visual disorders
□ Constant fatigue	□ Arm/Leg pain	□ Poor co-ordination
□ Learning difficulties	□ Recurrent stomach aches	□ Digestive disorders
□ Scoliosis	□ Fever	□ Convulsions
□ Joint pains	□ Asthma	□ Travel sickness
□ Night terrors	□ Seizures	□ Chronic colds
□ Recurring fevers	□ Hip problems	□ Other _____

MEDICAL HISTORY

How long did your child crawl for? _____Months

Is your child accident prone? Yes / No Has your child had any significant falls? Yes / No

Please describe any falls or accidents your child has had:

_____

_____

Has your child ever been involved in a motor vehicle accident? Yes / No

Is your child on medication? Yes / No

Has your child been vaccinated Yes / No

History

Has your child had any diseases / illnesses? Yes / No

Has your child ever been hospitalized or had surgery Yes / No

If yes, please describe:

_____

_____

Has your child ever been assessed for the scoliosis (curvature of the spine)? Yes / No

Has your child had a learning problem or possible disorder? Yes / No

How many times has your child taken antibiotics? In last six months _____ During Lifetime _____

How many doses of other Prescription Medication has your child taken?

In last six months _____ During Lifetime _____

PREVIOUS CHIROPRACTIC CARE

Has your child had previous chiropractic care? Yes / No

Reason for care _____

Date of last care _____/_____/_____ Name of Chiropractor _____

Were x-rays taken? Yes / No

How would you describe the care received? Excellent □ Good □ Fair □ Poor □

CHIROPRACTOR'S HISTORY (To be filled out by Practitioner)

_____

_____

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Name of Practitioner _____ Date _____

Chiro 4 Family Wellness - **Consent to Chiropractic Care**

Chiropractic care is recognized as being an effective and safe modality of care for both adults and children. However, as with all health care procedures there is a health risk which you are required to be informed about. This is not meant to frighten you it is simply to make you better informed.
The risks of a child experiencing an adverse reaction to chiropractic care is extremely rare and has been estimated at between 1 in 250 million and 1 in 700 million chiropractic adjustments.

In adults chiropractic care is also a very safe form of health care. Part of this care may involve cervical (neck) manipulation. We feel it is important that you are aware that as with any health care procedure there is some risk associated with cervical manipulation. This risk is currently estimated at 1 in 1,000,000 for stroke or stroke like symptoms. This is a rare and unpredictable event. Other risks that can be associated with spinal adjustments include disc injuries, rib fractures, sprains/strains or pre-existing conditions may be aggravated. We take every precaution to ensure that this risk is minimized through thorough testing, examination and the use of gentle and specific techniques. If you have any concerns, please let your chiropractor know.

Please read the following carefully:

- ❑ I acknowledge that I have discussed with the treating Chiropractor the rare risks associated with my / my child's proposed care which include although are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries, strokes (or like episodes) and an exacerbation and/or aggravation of my / my child's underlying condition.
- ❑ I also acknowledge the following additional potential risks insofar as my / my child's proposed care is concerned have been explained to me.
- ❑ I have also had the opportunity to discuss the proposed care with the treating Chiropractor and 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. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.
- ❑ I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
- ❑ I hereby acknowledge my consent to the performance of the proposed chiropractic care by and/or any other chiropractor working in this clinic. I understand that I can withdraw consent at any time.

Adult

..... ……

Patients signature Patients Name (printed)

Child / Minor (*parent or guardian if patient is under 18)*

……. ……. ……

Parents' signature Childs name (printed) Dated

Office Use Only (*To be completed by DC or CA)*

…… ……

Witness to patient's signature Dated

Privacy Statement…..This practice collects your personal information to assist us in providing a service to you. We recognize and support your right to privacy in relation to this information.

*Please tick if you **do not agree** to the following:*

- ❑ To a 'thank-you letter' being sent to the person who referred you to us.
- ❑ To your name being added to our referral board when you refer a new patient to us.
- ❑ To correspondence being sent to you via email.