Confidential Patient Information

CHIRO4FAMILY WELLNESS
Family Healthcare Naturally

Personal Information Children 6-18 Years

Who may we thank for referring you?		
Name of Child:		Date:
Address:		Postcode:
Parent's Home Phone:	Mobile:	Work:
Parent's Email Address:		
Date of Birth:	Year at school:	
Mothers name:	Father's name:	
Names and ages of other children		
Private Health Fund:		
Doctors Name & Address:		

Addressing What Brought Your child Into This Office:

If your child has no symptoms or complaints and are here for Chiropractic Wellness Services, Please skip to the "General Health History"

Health Concerns

Please list your child's health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If your child had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1					
2					
3					

Is your child's pain dull? Or is it pain sharp? Does it radiate anywhere? If so, where?

_____

_____

Since the problem started, is it: About the same? Getting better? Getting worse? What have you done for this condition? Was it of benefit?

_____

_____

Which activities aggravate your child's condition?

_____

What makes your child's condition feel better? _____

Other doctors your child have seen for this condition: _____

Is this condition interfering with any of the following?

Schooling Sleep Daily routine Sport/exercise Other (please explain):

General Health History

Has your child had any surgery? (Please include all surgery)

1	When?
2	When?

Has your child had any accidents and/or injuries; car, sport-related, or other?
(Especially those related to your present problems).

1 Type	When?	Hospitalized? Yes No
2 Type	When?	Hospitalized? Yes No
3 Type	When?	Hospitalized? Yes No

Has your child ever had x-rays taken?

Area of body?	When?	Where?

Does your child wear orthotics or heel lifts? Yes No

Past Health History

Please mark the following conditions your child may have had or have now (- have had or + have now)

Allergy	Arm/Leg pain	Asthma	Back Pain
Bed wetting	Bowel Problems	Chronic colds	Chest Infection
Constipation	Diarrhoea	Digestive Pain	Ear Infections
Eczema	Fatigue	Fevers	Growing Pains
Headaches	Hip Problems	Hyperactivity	Joint Pain
Learning Issues	Loss of Appetite	Neck Pain	Scoliosis
Sinus Pain	Stomach Aches	Tonsillitis	Tight Muscles
Travel Sickness	Trouble Sleeping	Visual Disorder	Other

Current Medicines and Supplements

Please list any medications/drugs your child has taken in the past 6 months and why: (prescription and non-prescription)

_____

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 had any diseases / illnesses? Yes / No Has your child ever been hospitalized or had surgery? Yes / No

If yes, please describe _____

If yes, please describe _____

Has your child ever been assessed for the presence of scoliosis? Yes / No Has your child had a learning disorder? Yes / No

How many times has your child taken antibiotics? In last 6 months _____ During lifetime? _____

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

In the last 6 months _____ During lifetime? _____

Previous Chiropractic Care

Has your child had previous chiropractic care? Yes / No

Reason for care _____

Name of Chiropractor? _____

Date of last care _____ / _____ / _____

Location of Clinic _____Were x-rays taken? Yes / No

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

_____ _____

Patient's Signature Date

Chiropractor's History **(To be filled out by Practitioner)**

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Chiro 4 Family Wellness – Consent Form

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.