New Patient Intake Form (Age 2 - 5years)

Thank you for choosing Spinewaves for your child's chiropractic care. Please complete the form in ink. The information you provide here will help us in understanding their condition and preparing their file. For us to decide whether their problem is suitable for chiropractic, we are required to assess all aspects of their current state of health. If you require help at any stage please ask, we are happy to help.

The files held at this clinic are STRICTLY CONFIDENTIAL.

Child's Name: ……………………………..………………………….. Date of Birth: ……..…..…………………

Mother's Name: ………………………………………Father's Name: …………..……………………………………

Address: ……………………..…………………………………………………..…………..…………………………...

……………………………..…………………………..…………….. Post Code……………………………………….

Tel (Home): ……..……...……..…..… Tel (Work): ………..……….…….…. Tel (Mobile): ……………………...……..

E-Mail Address:………………..…………………………………………………………………………………………….

☐ **Please tick if you DO want newsletters / health tips / advice**

G. P./Surgery Name……………………..………………………………………………..……………………………..

Do you have any health insurance? Yes No Which company..

How did you hear about Chiropractic / this clinic? GP Health Visitor Friend/Family………………………

Internet search Our website Advert Other: ……………………………………………….

Present Complaint:………………………………………………………………………………………………….……..

Have you consulted anyone else?: ……………………….………………………….……..……………………………...

Is your child on any medication? ……………………………………………………………………………………........

Has your child had any medical treatment / scans / x-rays / surgery?: ………..………..……………………………………..

Was your child born with any congenital disorder?: …………………………………………………….………………….

Any road traffic accidents or other accidents?..

Has your child had any vaccinations?....................................Any reactions?:...

Has your child had any childhood illnesses?..

Any known allergies?: …………………………………………………………………………………………………….

Does your child have a good diet? ……………………………………………………………………………………….

Regular bowel movements?: …………..…………………………………………………………………………………

Does your child sleep well? Yes No

Is your child dry by day Yes No

Dry by night? Yes No

Number & ages of siblings...

Any other information you think might be relevant? ……………………………………………………………………

………

PRENATAL / BIRTH

Any maternal illness or drugs during pregnancy?: ……………………………………………………………………

Were there any complications during delivery?..

How was your child fed? Breast Bottle Both When did they start solids?...

Milestones:
Tick if achieved / cross if not achieved:

7 months - sits unaided…………… 9 months - stands unsupported……………..

Did your child bum-shuffle? Yes No

11 months – crawling ……………….. 14 months - walks unaided…………………..

2 years – says short sentences……. 3 years – self dressing………………………..

FAMILY MEDICAL HISTORY
(parents/siblings)

- Allergies	Yes	No
- Reflux/IBS	Yes	No
- Asthma	Yes	No
- Headaches/Migraines	Yes	No
- Skin disorders	Yes	No
- Delayed Development	Yes	No

Data Protection Policy

Under the General Data Protection Rules (2018), as a health service provider, we are required to advise our patient(s) on our Data Protection Policy for the purpose of consultation, examination and treatment. As part of the patient record, the clinic is required to retain information for the purpose of consultation for treatment, recording subsequent treatments, and for use by third party medical practitioners only, at the request of the patient, in writing. Information will be held both manually and electronically in files accessible only by staff of the Clinic who are directly involved in the data entry and processing of patient records. Information will be kept for as long as the patient remains a patient of the Clinic, and thereafter for a period of 8 years (or age 25 if longer), after which the patient has the right for their data to be erased, providing there is no overriding legal reason. All information provided will be treated as confidential, and will not be given to any other person(s)/organizations(s) without the explicit consent of the patient concerned. With the exception of Employees, Partners and Owners of the practice. Our full Privacy Policy is available in the clinic patient information folder and can be found on our website: **www.spinewaves.co.uk/info/privacy**

Informed Consent to Treatment - To be completed after Examination and Review of Findings

- ☐ **I have received a full explanation of my child's condition including Differential diagnosis**
- ☐ **I have had the opportunity to ask questions**
- ☐ **I have been advised of care options and the likely benefits.**
- ☐ **I understand that reassessments and reviews will be performed at 6-12 visit intervals**
- ☐ **I have been advised of possible side effects and risks associated with treatment**

I the authorised Guardian, **understand** my child's condition and the proposed care plan as it has been explained to me. **I agree** to the procedure(s) and/or course of chiropractic care as described. I have been made aware and understand the clinic data policy.

Parent's Signature	Name (PRINT)	Date