New Patient Intake Form (Birth - 2years)

Thank you for choosing Spinewaves for your baby/toddler'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: …………………………………………………Occupation:………………………………………………

Father's Name: …………………………………………………Occupation:………………………………………………

Address: ………

…………………………………………………………………………… Post Code…………………………………………………

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

E-Mail Address:……

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

G. P./Surgery Address: ……………………………………………………………………………………………………

Health Visitor: …………………………………………………… Do you have any health Insurance?…………………………

Names & ages of siblings……………………………………………………………………………………………………

How did you hear about Chiropractic / this clinic?: ………………………………………………………………………

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

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

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

Are you or your baby on any medication?………………………………………………………………………………

Was your baby born with any congenital disorder?: ………………………………………………………………………

Is there any family history of illness?:……………………………………………………………………………………

Has your baby had the following vaccinations? 1st dose *5-in-1*.... DTaP/IPV/Hib (2 mo) ☐

2nd dose *5 in1*....Meningitis (3 mo) ☐ 3rd dose 5-in-1…Pneum/Mening (4 mo) ☐

Menin/ Hib B/ MMR/ Pneumo (12 mo) ☐ Any reactions?:………………………………………………………

Has your baby had any childhood illnesses?……………………… Any known allergies?: ……………………………………

Are there any feeding difficulties?: ……………………………………Any difficulty latching on?……………………………

Is/was the baby on Bottle ☐ Breast ☐ Both ☐

When was your baby weaned (if applicable)……………………Easy to wind?: ……………………………………………

Any reflux/vomiting?…………………………………………………… a little ☐ a lot☐ projectile☐

Sleep well?:……………………………………………………… Use a dummy?: ……………………………………………

Constant crying?: …………….. Regular bowel movements?: …………………. Any asymmetry?............................

How many wet nappies a day?.......................... Any sticky eyes? …………….. If so, Left or Right?..........................

PRENATAL / BIRTH

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

Number of previous pregnancies:…………………….... Number of ultrasound scans?: …………………………………

Duration of Birth: (from onset of labour)…………….………………… 2nd stage……………………………………………

Length at birth……………………………………………....... Weight at birth……………………….…………….…………

Head circumference……………………………………… AGPAR Score:…………………………………………………...

Was the Birth: (Please circle any of the following that apply)

Premature	Due date	Overdue by______________________________	days/weeks
Induced	Forceps	Ventouse	
Breech	Face or forehead presentation		
If Caesarean	Planned	Emergency	
Did the Baby Have:	Bruising	Jaundice	Special Care…………………………………...

MILESTONES:
Tick if achieved / cross if not achieved yet

6 weeks	smiling…………………………………	3 months	Head steady……………………………....................
7 months	sits unaided……………………… ….	9 months	stands unsupported…………………………………
11 months	crawling………………………………	12 months	2 or 3 recognisable words…………....................
14 months	walks unaided………………………	16 months	holds and drinks from a cup………………………..

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