Date: ____/____/____

CHIROPRACTIC PAEDIATRICS

Mast O Miss O Full name: ____

Address: ____________________________ Suburb & Postcode: _____________________

DOB: ____/____/____ Phone (H):__________________ (M): ______________________

Email: ____

Mother: _______________ Father: ________________ Contact number: _____________

Name of General Practitioner: _______________________ GP Phone: ________________

GP address: ____ Post Code: ________

How did you hear about us? ___________________ Health fund: ____________________

Were there any illnesses, injuries, surgeries, or prenatal difficulties? O Yes O No ____________

Was delivery: Natural / Caesarian Other: ____

Were forceps or suctioning used? O Yes O No

What was the child's birth weight? ____

Were there any complications following birth? (respiration, transfusions, tube feeding) O Yes O No

Was the newborn hospitalization unusually long? If so, why? O Yes O No ________________

Were there any feeding difficulties as an infant? O Yes O No ___________________________

Has your child had any significant childhood illnesses? If so, please explain. O Yes O No

____

Has your child been treated for any physical medical problems? If so, please explain. O Yes O No

____

Does your child have frequent ear aches or ear infections? O Yes O No

Has your child had any significant physical injury? If so, please explain. O Yes O No

____

Does your child have any allergies, food sensitivities, dietary restrictions? If so, please specify.
O Yes O No ____

Have you had your child's hearing tested? O Yes O No

Does your child wear glasses? If so, what is the correction for? O Yes O No ______________

Is your child currently taking any medications? If so, please list. O Yes O No ______________

____

Has your child had their recommended immunizations? O Yes O No

Has your child had toxicity testing? O Yes O No

Does your child use any adaptive equipment? If so, what? O Yes O No ___________________

Does your child use any home therapy equipment (trampoline, swing, brushing)? If so, please specify. O Yes O No ____

Does your child have sensory needs or sensory defensiveness to touch, sound, texture, odors, or level of stimulation? O Yes O No

Does your child sleep on their: O Side O Back O Stomach? How many pillows does he/she use? ___

Child's Developmental History:

At what age did your child reach the following milestones?

Roll over from stomach to back and back to stomach ____

Sit independently ___________________ Crawl ____________________ Walk ____________________

Speak his/her first word ____________ What was it _____________ Combine words ___________

Speak sentences _________________________ Dress self independently ______________________

Drink from a cup independently_____________ Feed self with a spoon independently____________

Describe your child at present by circling characteristics that most closely fit him/her:

O difficulty learning	O difficulty separating from primary Caretaker	
O fights frequently	O has frequent temper tantrums	O has nervous tics or habits
O has unusual fears	O impulsive	O is clumsy/falls often
O is easily frustrated	O is mostly quiet	O is overly active
O is resistant to change	O is restless	O is stubborn
O is usually happy	O over reacts	O rocks self
O talks constantly	O tires easily	O wets bed frequently

O Any other concerns: ____

Speech and Language History:

Do you have any concerns regarding your child's speech and/or language development?
O Yes O No If so, please describe ____

____

How does your child make his/her wants and needs known? __________________________________

____

Does your child play with toys differently from other children his or her age? O Yes O No
If so how? ____

____

Do you have concerns with how your child interacts and communicates socially? O Yes O No

Does your child have special interests that he/she knows a lot about and seems to want to talk about at length often to the exclusion of other topics and without regard to the listener? If so, what is/are the special interest (s)? O Yes O No ____

____

Does your child have difficulty understanding nonverbal communication (facial expressions, gestures, physical space, and tone of voice) or seem unaware of those communication cues?
O Yes O No ____

____

Family History

Does your family have a history of speech, language or learning difficulties? O Yes O No
If so, please explain who and their relationship to this child. ________________________________

____

Is there a family history of related medical diagnoses (physical or emotional)? O Yes O No
If so, please explain. ____

____

Goals:

I would like to see my child be able to: ____

____

What does your child like to do? ____

____

What does your child dislike? ____

____

Has your child received therapy services in the past? O Yes O No
If so, where and may we have copies of those reports? ____________________________________

____

Parent/Guardian consent:

At A.C.E. Wellness we aim to provide the highest Quality 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. The risk is currently estimated at 1 in 1,000,000 for stroke and stroke like symptoms. This is a rare, random 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 the risk is minimised through thorough testing, examination and the use of gentle and specific techniques. If you have any concerns, please let your chiropractor know.

I acknowledge that I have read the consent to chiropractic care and understand that if at any time I have concerns they can be discussed with my child's chiropractor. I appreciate that my child will receive the best care possible at A.C.E. Wellness but that results can not be guaranteed.

I understand my child's client information is confidential; however A.C.E. Wellness may need to correspond with various third parties, including GP, Specialist or Insurance Companies.

I give permission for A.C.E. Wellness to release my child's information for this purpose. I also give permission for my child's photograph to be taken by A.C.E. Wellness for the sole purpose of being added to my client file for security reasons.

Parent/Guardian Signature: ___________________ Date: ___/___/___ CA Signature__________

A.C.E. Wellness provides a SMS service to remind you of your appointments. All clients are automatically enrolled in this service. If you do not wish to have this service, please indicate below:

O Please do not send me SMS reminders for my appointments.

PAYMENT OF ACCOUNTS

Thank you for choosing A.C.E. Wellness as your specialised wellness centre. We recommend that you read the following information concerning payment of your account. At A.C.E. Wellness, we pride ourselves on the relationships we have between ourselves and our clients.

The trust we have between our clients and ourselves is paramount in the provision of treatment for you. For this reason, we ask you to always provide us with the most up to date information concerning your address, contact details and status of your claim.

Liability for payment of your account for treatment always rests with you as the recipient of our services here at A.C.E. Wellness. This also includes the situation where the insurer or other organisation or body nominated by you declines to pay for any reason.

If you are pursuing a Workers Compensation, Motor Accident claim or other legal proceedings arising from the injuries for which we are treating and the relevant insurer has accepted liability for medical treatment, then you should inform us without delay and provide us with the relevant documents specifying the insurer and claim number. A.C.E. Wellness can then forward accounts directly to the insurer for payment.

If however the insurer declines to pay such medical payments, or ceases paying during treatment, then you are liable for payment. As a matter of course however, if you are proceeding with a claim you should forward these paid accounts to you solicitor so they can be included in your claim and reimbursed to you at the end of proceedings.

Regrettably A.C.E. Wellness can not continue to provide services to you for accounts remaining in arrears for longer than 28 days, after which time A.C.E. Wellness also reserves the right to claim interest at the rate of 10% per day.

Please note that a cancellation fee of $25.00 will apply for any cancellations where less than 5 hours notice has been provided.

The team at A.C.E. Wellness look forward to continuing to strive to provide you with the best services available. Should you at any time have any questions concerning our account practices, please don't hesitate to contact us.

The above statements are not meant to cause offence, but have to be included to comply with the legal requirements concerning the provision of billing information. Please note that the outstanding accounts will be reported to the National Debt Default Register. This will affect future credit applications.

I acknowledge that I have been informed of the Payment of Accounts procedures at A.C.E. Wellness and agree and comply with these.

Signed: ____________________________ Date: ___/___/___ CA Signature: ________________________