New Patient History Child (Under 12 years)

File _____

The completion of this form is a sensible first step prior to experiencing the many benefits associated with chiropractic. This form has been designed to assist with delivering the most appropriate chiropractic treatment and/or identifying any possible risk factors to your health and safety to provide appropriate care and advice.

GIVEN NAMES:_____SURNAME:_____DOB:__/__/_____

RESIDENTIAL ADDRESS: _____

SUBURB:_____STATE:_____POST CODE: _____

Parent/Guardian 1 Name:_____Contact Number: _____

Email Address: _____

Parent/Guardian 2 Name:_____Contact Number: _____

Name/s & age/s of siblings:_____

Do you have Private Health Insurance Yes / No If Yes, which Fund _____

How did you hear about us? Yellow Pages_____Google_____Signage_____Staff_____

Clinic Patient (please provide their name so we can thank them)_____Other _____

YOUR CHILDS HEALTH HISTORY

Would you like your child to receive wellness care Yes / No
Reason for this visit today (what is the patients chief complaint): _____
When and how did symptoms start: _____
What makes the symptoms better: _____
What makes the symptoms worse: _____

Details of past treatment: _____
Do you have any other Health Professionals who have cared for your child: Yes / No
Please list any details here: _____
Date of last spinal Examination?_____

Please indicate any current condition your child may have or has had in the past (please circle):

ADD/ADHD	Abnormal gait/limping	Abnormal Stools	Autism Spectrum
Asbergers Syndrome	Bedwetting	Asthma	Back pain
Colic	Convulsions	Behavioural issues	Constipation
Balance issues	Diarrhoea	Colds/Flu	Recurring fevers
Digestive issues	Difficulty sleeping	Ear Aches	Vomiting
Headaches	Pain in bowel movement	Poor school performance	Unusual attachment to toys/pets
Nose Bleeds	Stomach pain	Extremity pain	Fainting spells
Scoliosis	Unusually clingy	Temper tantrums	Constant crying

Please list any other condition your child maybe experiencing or has had in the past _____

_____

_____

Please indicate if applicable to mothers labour and or delivery:

Caesarean	Complications	Homebirth	Induced Labour
Epidural	Longer than 12 hours	Longer than 20 hours	Premature Delivery
Use of Foetal Monitor	Use of Forceps	Use of Vacuum	Vaginal Birth
Other:			

Please indicate or fill out all that apply to your child at birth:

Birth Weight	Choking	Circumcision	Crying
Duration of Pregnancy Weeks:	Erythromycin	Feeding by bottle	Breast Feeding
Hep B Vaccine	Medications	Jaundice	Pale
Respirator	Sleeping Concerns	Vitamin K	Other

Injuries/Surgeries

Falls:_____
Head Injuries/Whiplash: _____
Broken Bones/Dislocations: _____
Surgeries:_____
Medications: _____

Has your child ever been involved in a motor vehicle accident? YES / NO

If yes, briefly describe: _____

Any treatment received? _____

This information is likely to be important. At the very least, it will help us get a better understanding of what's going on with your child's health. The following questions are regarding your child's current health concerns:

Are there any health concerns? _____
If so, for how long has this been occurring? _____
Are there any other conditions being experienced? _____
How long has this been ongoing? _____
How often does your child have this condition? _____
Is the patient on and medication? _____

Please note that any and all information, written or otherwise, that you give us is strictly confidential and is so treated by the entire staff. No information or records will be released to any person, health fund, insurance company or any doctor without the written permission of the patient.

We would like to include you on our email list so you receive our health updates and special offers, please check this box ☐ if you DO NOT wish to receive these emails.

Consent To Chiropractic Care

When performed by a qualified chiropractor, spinal manipulation is effective and safe method of treatment for many conditions. There are, however risks associated with any treatment and we are required to inform you of these, even though there has never been a serious injury in ourclinic. Please read the following carefully, and write down any questions you may have.

I hereby request and consent to the performance of chiropractic treatment on the patient named below by Dr Luke Hennessy Bsc. M Chiro and/or any other Chiropractor practicing in this clinic, authorised by Dr Hennessy.

I understand, and I am informed that, as in the practice of medicine, in the practice of Chiropractic there are some very slight risks to treatment, including, but not limited to, muscle and joint soreness, muscle strains, joint sprains, fractures, disc injuries, strokes and stroke-like episodes.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the treatment, which the doctor feels at the time, based upon the facts then known, is in the best interests of the patient named below.

I am aware that this clinic works on an open door policy and that I can request the presence of a Chiropractic Assistant at any stage of the patient's care.

I understand that neither I, nor any persons accompanying me, are permitted to use recording devices whilst in the practice unless prior approval has been granted by the Chiropractor.

I have read the above, and I have also had the opportunity to ask questions about its content.

I intend this consent form to cover all treatment for which the below named patient presents. I understand that the consent can be withdrawn at any time.

I hereby authorise the Chiropractor to perform any necessary diagnostic procedures to fully evaluate my child's condition for the presence of vertebral subluxation.

Patient Name: _____

Parent/Guardian Name:_____Signature:_____Date:___/___/20___

I am aware that my initial consultation is free, with no obligation to progress to a comprehensive examination and or treatment. However, I understand that I am responsible for payment of fees incurred on the day of service if I choose to proceed to the examination. I also understand that any "third party" claims through Medicare (EPC), Department of Veterans' Affairs and or Workcover will be my responsibility if the "third party" rejects the claim.

Parent/Guardian Name:_____Signature:_____Date:___/___/20___