AUTHORISATION FOR EXAMINATION OF A MINOR

I here by authorise this clinic and its Doctors of chiropractic/therapists to administer an examination as they deem necessary to my child (upon approval of parent or guardian). I realise that I am responsible for all fees charged by this office and I agree to pay for all services provided.

Relationship to child: _____

Signed: _____ Date: _____

PRIVACY POLICY CONSENT *Refer to our website for full policy wording* **- Please delete as appropriate:**

I consent / do not consent to Aberdeen Chiropractic Clinic using my contact information to send appointment reminders by telephone, email or SMS.

I consent / do not consent to receiving newsletters, offers and marketing information from Aberdeen Chiropractic Clinic

Signed: _____ Date: _____

AUTHORISATION OF TREATMENT OF A MINOR

I acknowledge that I have had the opportunity to discuss with my Chiropractor, the nature, purpose, risk and benefits of Chiropractic Care in general and the minor child's management (including spinal adjustments).

I consent to the Chiropractic Care offered or recommended for the minor by the chiropractic, including spinal adjustments. I intend this consent to apply to all present and future Chiropractic Care.

I understand that the information recorded in the files, x-rays or through any correspondence will remain in this clinic and will be treated with utmost confidence.

To be completed by parent or legal guardian:

Signed: _____ Name (Please Print) _____ Date: _____

Paediatric Patient Form (0-12 Years)

Aberdeen Chiropractic Clinic
your health & well being since 1979

Date: ( ) Practitioner: ( ) Service Type: ( ) Patient ID: ( )

Confidential Patient Information

The Paediatric Patient Form is used for children age 0-12 presenting to Aberdeen Chiropractic Clinic for their first spinal check-up, for muscular and skeletal conditions and for first baby check-up after birth. If your child has any chronic medical or developmental concerns, please use the Advanced Paediatric Patient Form.

Name: _____ Age: _____ Date of Birth: _____

Address: _____ Town: _____ Postcode: _____

Tel. (Home): _____

Mother's Name: _____ Date of Birth: _____ Mobile: _____

Father's Name: _____ Date of Birth: _____ Mobile: _____

Mother's Email: _____

Father's Email: _____

Male/Female: _____ No of Siblings: _____ Referred/recommended by: _____

Name of GP and Surgery _____

Name of Midwife/Health Visitor: _____

How did you hear about us? (e.g. friend / family / internet / event / location) _____

Are you here because of corporate agreement (If yes which company?) _____

Are you covered by private medical insurance? (If yes which company?) _____

Birth Weight:	Birth Length:	Current Weight:	Current Length:
Purpose of Visit: If purpose of the visit is a general check-up, go directly to the Pregnancy and Birth History below: If you have a particular concern please fill out all sections.			
What is the concern?			
When did it start?	Sudden or Slow onset?	Relieving factors?	Aggravating factors?
Current and previous treatment?			
Is the condition getting better or worse with time?			

Pregnancy and birth history

Did you have any problems during pregnancy?

How did you experience the birth?

Third trimester presentation: ☐ Vertex ☐ Breech ☐ Transverse ☐ Face/Brow

Type of birth: ☐ Normal Vaginal ☐ Forceps ☐ Cesarean ☐ Suction cap/vacuum/kiwi

Location of birth: ☐ Home ☐ Midwife Unite/Birthing Centre ☐ Hospital

Delivery / Birth History / Experience, were there any problems?

The Childs History

Jaundice? (yellow) Cyanosis? (blue)

APGAR Scores:

Congenital Anomalies / Defects: Yes / No

If yes please explain:

Infant Feeding:

Breast: Bottle: If bottle, which formula?

Number of hours sleep per night?

Quality of Sleep: ☐ Good ☐ Fair ☐ Poor

Date of last GP or Health Visitor visit:

Reason for visit:

Vaccination History:

Medication History:

Doses of antibiotics child has taken: In the past six months: During lifetime:

Has your child had a reaction to any medication, vaccine, environmental toxin, supplement or food group?

Previous Chiropractor or other practitioners visited:

Date of last visit: Reason for visit:

Has your child ever been treated for an emergency? ☐ Yes ☐ No
Please give details:

At what age did the child:

Respond to sound? _____ Follow an object with eyes? _____ Hold head up? _____

Sit alone? _____ Crawl? _____ Stand? _____ Walk alone? _____

At what age did the child suffer from the following childhood diseases?

Chickenpox? _____ Mumps? _____ Measles? _____ Rubella? _____

Rubeola? _____ Whooping cough? _____ Other? _____

Has the child suffered from:

☐ Headaches	☐ Orthopaedic problems	☐ Digestive disorders	☐ Behavioural problems
☐ Dizziness	☐ Neck problems	☐ Poor appetite	☐ ADD/ADHD/Concentration
☐ Fainting	☐ Arm problems	☐ Stomach aches	☐ Delay developmental
☐ Seizures/Convulsions	☐ Leg problems	☐ Reflux	☐ Muscle pain
☐ Heart trouble	☐ Joint problems	☐ Constipation	☐ Growing pains
☐ Earaches	☐ Backaches	☐ Diarrhoea	☐ Hyperactivity
☐ Sinus troubles	☐ Poor posture	☐ Diabetes	☐ Ruptures/Hernia
☐ Asthma	☐ Scoliosis	☐ Hypertension	☐ Skin condition
☐ Colds/Flu	☐ Walking trouble	☐ Anaemia	☐ Excessive crying
☐ Colic	☐ Broken bones	☐ Bedwetting	☐ Allergies to:
☐ Eczema	☐ Illnesses or infections	☐ Teeth/Teething/Braces	

Has your child suffered any of the following trauma that could affect the spine and nervous systems?

☐ Fall in baby walker	☐ Fall from couch	☐ Fall off skateboard/skates
☐ Fall from cot/bed	☐ Fall off swing	☐ Fall off bicycle
☐ Fall from highchair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off climbing frame	☐ Other:
☐ Bangs/Knocks esp. head	☐ Heavy falls	

Has the child ever sustained an injury playing organised sports? ☐ Yes ☐ No

Has the child ever sustained injuries in a car accident? ☐ Yes ☐ No

Surgery/Operations:

List any other concerns or relevant history:

Family History:

www.aberdeenchiropracticclinic.com