COMPLETE CARE HEALTH

To be completed by parent/guardian for children under 5 years of age

Patient information (child) Date: ___ / ___ / ___

Name: _____ DOB: _____ Sex: M / F
Title First Surname

Full Address (*inc postcode*): _____

Parent/Guardian: _____ Contact number: _____

E-mail: _____

Medical Doctor: _____

How did you learn about the Complete Care Health? If referred by a friend, who *(full name please)*?

_____

Has your child seen a Chiropractor/Physiotherapist before? Name: _____

What is the present complaint? _____

How did it begin? _____

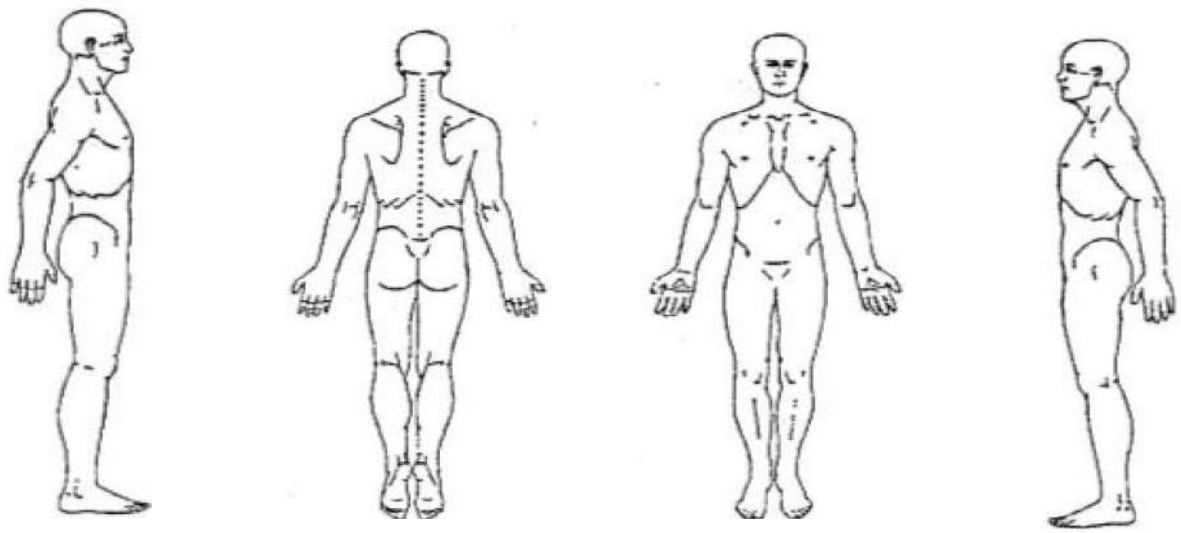
How long has your child been experiencing the symptoms mentioned?

☐ Years _____ ☐ Months _____ ☐ Weeks _____ ☐ Days _____

Do you feel they are: ☐ Improving ☐ Getting worse ☐ No change

Please indicate the type of pain below and specify the area with the letter shown:

A – Ache **B** - Burning **P** – Pins and Needles
N – Numbness **S** – Stabbing **O** – Other _____



Place a mark on the line below indicating their pain level:

0 10
No Pain Worst Pain

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Practitioner's comments – for office use only

Past medical history (please complete the following)

Any past surgeries (tonsils / appendix), accidents (e.g motor vehicle), injuries (sporting falls), illnesses, hospitalisation / fractures / dislocations.

Incident	Year

List of recent diagnostic procedures (e.g X-Rays, MRI's, CT scans, Ultrasounds, Blood, Urine, Stool Tests)

Test	Findings

Family History_____

_____

Medical Conditions (tick which applies to your child)

☐ Anxiety
☐ Depression
☐ Bed Wetting
☐ ADD/ADHD
☐ Ear or Other Infections
☐ Difficulty Gaining Weight
☐ Back/Neck Pain/Stiffness
☐ Constipation/Diarrhoea
☐ Diabetes
☐ Overweight
☐ Headaches
☐ Detachment/Distant
☐ Fatigue/Sleep Issues
☐ Autism/Asperger's
☐ Nausea/Vomiting
☐ Asthma/Chronic Bronchitis
☐ Frequent Sickness
☐ Irritability/Nervous/Restless
☐ Sinus Troubles/Allergies
☐ Colic/Acid Reflux
☐ Learning Disorders
☐ Other: _____

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Medications

☐ Anxiety ☐ Asthma ☐ Pain Narcotics ☐ Antibiotics

☐ Depression ☐ Acid Reflux ☐ ADD/ADHD ☐ Digestive

☐ Migraine/Headache ☐ Other: _____

Vitamins/Supplements

☐ Multi-Vitamin ☐ Vitamin D3 ☐ Fish Oil/Omega-3 ☐ Probiotics

☐ Other: _____

Lifestyle

Does your child exercise daily? Yes No How much? _____

How long does your child sit daily? Yes No How much? _____

Does your child sit: supported / unsupported

Does your child eat balanced meals? Yes No

Does your child/baby have difficulty sleeping? Yes No Explain:

_____

Prenatal history

Location of birth:

☐ Home Birthing Centre ☐ Hospital ☐ Other: _____

Did any of the following happen during delivery?

☐ C-section delivery ☐ Anaesthesia

☐ Labour was induced ☐ Forceps/vacuum extraction

☐ Special medical procedures/tests ☐ Premature delivery

Describe any of the above plus any additional complications experienced during delivery:

_____

During pregnancy, did you use any drugs, tobacco, alcohol, and/or medications? If yes, please list: _____

Did you experience any illness while pregnant? Yes No

If yes, explain: _____

Do you have any physical disabilities? Yes No

If yes, explain: _____

Birth weight: _____ Birth length: _____

How many sleeps per day for your baby? _____ How long? _____

Ultrasound used during pregnancy? Yes No No of times: _____

Did you breastfeed the baby? Yes No If yes, how long: _____

Did you formula-feed the baby? Yes No If yes, how long: _____

At what age did you introduce: solids: _____ cow's milk: _____

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Understanding the risks of Manipulation & Dry Needling

Manipulation is a safe, effective and appropriate way to care for many spinal complaints.

The most common adverse effect of manipulation is *minor stiffness* after the first treatment, which affects about 4 percent of patients receiving manipulation. The most serious risk identified with cervical manipulation is a condition known as *vertebrobasilar stroke (VBS)*, which occurs more commonly with individuals suffering from artery disease. The risk of this complication arising from upper cervical manipulation is extremely unlikely. According to, "The Appropriateness of Manipulation and Mobilization of the Cervical Spine," between one in every million patients and one in every 3.8 million treatments may experience *VBS*. Lesser risks include; sprain, injury to a ligament or disc in the neck (less than 1 in 139,000) and lower back (1 in 62,000). Most patients receive cervical manipulation as for specific problems such as muscle tension, stiffness, headaches or injury, or part of their regular mobility maintenance.

The possible risks and adverse reactions to dry needling therapy include but are not limited to; temporary pain, bleeding, bruising, infection, dizziness, nerve injury, pneumothorax, changes to blood pressure, rash, fainting, muscle soreness & fatigue.

I hereby acknowledge and understand the above risks and, consent my child to undergo manipulative care and dry needling.

If your child is about to receive clinical care, please tick one of the following

I consent my child to undergo clinical care ☐ **Yes** ☐ **No**

Privacy and Compensation Agreement

I understand that my mobile number and e-mail address may be used for communication purposes within the clinic, if you don't wish for this to happen, please notify reception. I understand that any x-ray films taken are my responsibility to keep, while the medical report is the responsibility of the clinic. The clinic will hold any films for three months, and thereafter if they are not collect, they will be destroyed. I hereby authorise any therapist, whether named in this form or not, to communicate and share information with my general practitioner or other health care provider to assist in my care. I clearly understand and agree that all services rendered are charged directly to me and, I am personally responsible for payment to the clinic. (In the case of a minor, this must be signed by a parent or legal guardian).

Patient Name: _____

Parental Signature: _____

Practitioner name: _____

Practitioner Signature: _____ Date: / /