Welcome, Parents and Children, to Vital Spines!

Your body is designed to be healthy. However, we experience physical, chemical and emotional stresses which can damage our health and quality of life. The effects are often gradual, accumulative and frequently are not felt until they become serious. The following questions will help uncover the layers of damage and your chiropractor will outline a course of care to begin to help correct these layers of damage.

CHILDS PERSONAL DETAILS

Name				**Mother's name**	
Address				**Father's name**	
Postcode				**Mobile Contact Number**	
D.O.B		**Age**		**Home Contact Number**	
Email				**Other Children's names**	
The Office Newsletter will be sent to the email address provided				**Other Children's ages**	
Emergency Contact Name and Relation				**Contact Number**	

How did you hear about us?

	Advertisement		**Referred by Another Patient** If so, by whom?
	Local Trader		**Internet Website/ Search Engine** If so, which website?
	Signage/Walk By		**Other** Please Specify

Have you received chiropractic care previously?

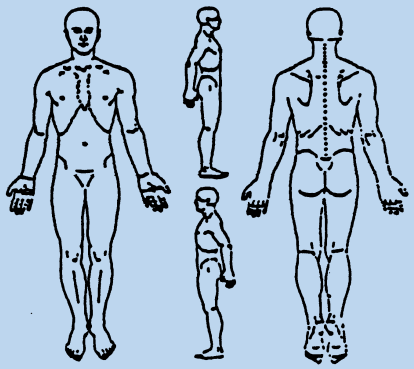
If yes, when was your last adjustment?	
From whom did you receive this care?	

HEALTH HISTORY

What are your main health objectives from attending this clinic?

	Relief of symptoms		Correction of an underlying issue		Maximise my / my family's health

What is the main reason for your visit? **Please indicate on the diagram where you experience your pain and/or symptoms**	....



When did this begin?	
How did this begin?	
Has this been an issue previously? If so, when?	
What (if any) activities aggravate the issue?	
What (if any) activities alleviate the issue?	
Have you consulted any other health professional for this use? If so, who?	

Please list any surgical operations the child has had, and the year they had them	
Please list any current medications or supplements, and their dosage	
Please list any major illnesses, or birth defects	

PREGNANCY/BIRTH

Birth Weight		**Apgar Score**		**Height**	

Which way did they crawl?

	Commando		Bum Shuffle		All Fours

During gestation, was the mother:

	Involved in any injuries or accidents		Ill or under undue stress

Do you believe the birth was Dramatic for you child? Yes No

Was the delivery:

	Normal		Breech		Posterior		Caesarean
	Premature		Full Term		Late		
	Difficult		Particularly Long		Particularly Rapid		Chemically Induced
	Forceps/Suction		In Hospital		At Home		

Please leave any other comments you would like to make about the birth	

CHILDHOOD

Was the child:		Breast fed		Formula fed	If so, for how long? _____

If breast feeding, were/are there any problems with:

	Attachment		Swallowing/choking		Sucking Strength		Fussiness

If breast feeding, was any assistance required, e.g. lactation consultant? Yes No If yes, whom? _____

Does the child suffer from:

	Reflux/Colic		Bedwetting		Earaches/Infections		Throat Infections
	Allergies		Headaches		Chest Infections		Seizures
	Hyperactivity		Asthma		Poor Coordination		Back/Neck Pain
	Learning Disorders		Disease/Illness		Broken Bones, if so which?		
	Flattening of the head		Torticollis		Forceps Marks/Bruising		Tongue Tie
	Swallowing or attaching problems		Hernia		Joint locking or clicking		Inability to weight bear

Have there been any issues with the following:

	Language Development		Following instructions		Social Skills		Co-ordination
	Gross Motor Skills (i.e. catching a ball)				Fine Motor Skills (i.e. drawing)		

INFORMED CONSENT

When performed by a qualified Chiropractor, spinal manipulation (adjustments) are an effective and safe method of treatment for many conditions. There are, however, risks associated with treatment, and we are required to inform you of these.

I hereby request and consent to the performance of Chiropractic treatment by the qualified Chiropractors caring for patients at Vital Spines Chiropractic.

I understand, and am informed that, as in the practice of Medicine, in the practice of Chiropractic there are some very slight risks associated with assessment and treatment, including but not limited to, Muscle and joint soreness, muscle strain, joint sprain, fractures, disc injuries, nerve injuries, stroke and stroke-like episodes, and/or exacerbation or aggravation of the underlying condition.

I do not expect the Chiropractor to be able to anticipate and explain all risks and complications, and I wish to rely on the Chiropractor to exercise judgement during the course of the treatment, which the Chiropractor feels at time, based upon facts then known, are in my best interest. I understand that results are not guaranteed.

I have read the above, and I have had the opportunity to discuss the nature and purpose of Chiropractic treatment and I have also had the opportunity to ask questions about its content.

I intend for this consent form to cover the entire course of my treatment for my present condition, and for any other future conditions for which I seek treatment.

I understand that I can withdraw my consent at any time

Patient Name (Please Print): _____

Signature of Patient/Guardian: _____

Signature of Chiropractor: _____

Date: _____