CHIROPRACTIC CHILD HEALTH HISTORY FORM

Welcome

The following information is strictly confidential and will assist us in determining your child's current and past level of body function.

Miss/ Mast (please circle)

Child's First Name _________________________ Child's Surname ___________________________________

Address ____

Suburb____________________________________

Post Code___________________ Date of Birth _____/_____/_____

Mother's First Name __________________________ Mother's Surname ______________________________

Date of Birth _____/_____/_____ Occupation ____

Phone (hm) _____________________ (wk) _____________________ (mob) ___________________________

Father's First Name ___________________________ Father's Surname ______________________________

Date of Birth _____/_____/_____ Occupation ____

Phone (hm) _____________________ (wk) _____________________ (mob) ___________________________

Which client referred you to us? ____

Do you have other children, if so how many? ____

Has your child been to a Chiropractor before? YES / NO (please circle)

Your child's General Practitioner ____

What is your child's main area/s of concern? ____

How long have they had this problem for? ____

Do you know what caused the problem? ____

Do certain activities exacerbate the problem, if so what?

____

Has your child had any previous treatment for this problem, if so what?

____

Has your child ever been hospitalised, if so for what?

____

List any surgeries your child has had & the date

____

Were there any pre-natal complications?

____

How long was the labour?___________________APGARS____________________________________

How was your child delivered, vaginal / c-section / forceps / von touss (please circle)

What was your child's weight when they were born? ____

Is your child gaining weight and height, normally / under / accelerated (please circle)

Does your child suffer from any neck stiffness, fever or headaches?

____

Have you noticed any changes in your child's alertness (eg. drowsiness, trouble talking, lack of concentration, loss of consciousness)?

____

Have you noticed any muscle weakness (floppiness) with your child? _____________________________

Please tick the appropriate box:

	Heavy	Moderate	Light	None
Feeding/ Eating	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐

Does your child have or experience any of the following conditions?: (please circle)

Heart condition	YES/ NO	Poor circulation	YES/ NO
Skin problems	YES/ NO	Irregular bowel movements	YES/ NO
Hormonal problems	YES/ NO	High or low blood pressure	YES/ NO
Difficulty breathing	YES/ NO	Changes in normal awareness	YES/ NO
Difficulty learning	YES/ NO	Changes in hand/feet temperature	YES/ NO

Accelerated pulse	YES/ NO	Changes in normal strength	YES/ NO
Poor digestion	YES/ NO	Changes in balance or coordination	YES/ NO

Allergies YES/ NO - If Yes, Please List_______________________________

What vaccinations has your child had? ____

List any medications & supplements your child is currently taking ____________________________________

____

List any childhood illnesses of the parents

____

List any major diseases of the parents____

List any family history diseases

____

Who is responsible for payment of this account? ____

Thank you. Please advise us if you have any concerns with the completion of this form.

Parent Signature ____________________________________ Date / /

INFORMED CONSENT FOR CHIROPRACTIC CARE

Scope of care: Chiropractic care is focused on finding and correcting spinal problems that alter the normal spinal shape and movement. Spinal problems may affect the healthy function of the nerves and spinal cord and be detrimental to health. Chiropractors correct spinal problems using forces applied generally by hand or special drop piece tables. These forces made are called adjustments. Chiropractors may use various exercise, traction devices, shoe lifts or other to help the spinal corrections.

Medication: Many patients experience great health improvements beyond spinal improvement and it is common for patients to report changes in medical health conditions. However, changes in medications or management of medical conditions needs to be done by your GP or specialist. Chiropractors cannot advise you as to your medical needs.

Alternatives To Chiropractic Care: If a patient does not wish to correct the spinal alignment and function then the alternatives are pain relief care with other health professionals or care designed to stabilise the spine such as core exercise.

Risks of Not Undergoing Care: Spinal problems may get worse if uncorrected or not managed and may lead to progressive damage of the spinal discs, the spinal nerves, the spinal cord and even general health.

RISKS TO PATIENTS: All types of care have associated risks and it is important that a patient accepts these before undergoing care. Adjustments require forces to move spinal bones and as such put stresses on blood vessels, bones, discs, nerves and soft tissues.

The below are some of the more serious and more common risks but it is not an exhaustive list.

a) **RARE BUT SERIOUS RISKS**: damage to the blood vessels, bones, discs or spinal cord may lead to death, stroke, paralysis or permanent injury.

b) **More Common** but less serious: Sprains, strains, rib fractures, bruising, inflammation and soreness.

The Chiropractor has gone through the risks of care and examination; I have been informed of the alternatives to care to my satisfaction. I have had the opportunity to ask any further questions or information from the Chiropractor or to ask for more time before signing the consent to care and examination.

Child’s Name:____

Parent/Guardian Signature:____

Date:_______________

Chiropractor ____