Transformation CHIROPRACTIC

Childhood Patient History

YOUR DETAILS

NAME: Title _____ First Name _____ Surname _____

GENDER: ☐ Male ☐ Female Date of Birth: ____ / _____ / _____ Age: _____

POSTAL ADDRESS: _____

Suburb _____ State _____ Postcode _____

NEXT OF KIN: _____ Siblings (number & ages) _____

TEL NUMBERS: Home _____ Mobile _____ Work _____

PREFERRED TEL: ☐ Home ☐ Mobile ☐ Work

EMAIL ADDRESS: _____

WE APPRECIATE REFERRALS. HOW DID YOU FIND OUT ABOUT OUR CLINIC?

☐ Family member ☐ Another Health Professional ☐ Online ☐ Our Signage

☐ Friend, please specify: _____

PRESENT STATE OF HEALTH

I would like my child to receive help for (primary concern): _____

Other concerns I would like addressed: _____

Does your child suffer from:

☐ Asthma	☐ Headaches	☐ Eczema
☐ Fatigue/Lethargy	☐ Poor Memory	☐ Easily Distractible
☐ Bed Wetting	☐ Irritability	☐ Poor Co-ordination
☐ Dislike of Reading	☐ Sore Eyes/ Blurred Vision	☐ Hay Fever
☐ Sinus	☐ Allergies	☐ Joint Aches/Pains
☐ Poor Handwriting	☐ Over-activity	☐ Tantrums
☐ Unusual walking patterns	☐ Poor Fine Motor Skills	☐ Speech Delays

☐ Other: _____

Has your Child had any other therapies or interventions?

☐ Behavioural Optometry	☐ Sound Therapy
☐ Occupational Therapy	☐ Speech Pathology
☐ Chiropractic	☐ Other: _____

Has your child been recommended for orthotics or glasses? YES / NO

Does your child have any food intolerances? (Please list)

_____

_____

Was your child's delivery:

☐ Vaginal	☐ Caesarian	☐ Forceps
☐ Vacuum Pump	☐ Breech	☐ Epidural Required
☐ 12 hours or longer	☐ Other: _____	

Were there any complications before, during, or immediately after the delivery?

_____

_____

_____

Is your child taking any medications?

Medication	Reason	Medication	Reason

Tests / Operations:

year	What Test/Operation	Year	What Test/Operation

Please mention anything else you may be concerned about with your child.

_____

_____

_____

PRIVACY POLICY STATEMENT

In accordance with the new Privacy Act, all information relating to your child is held in total confidence.

However, your consent is hereby requested to allow us to exchange information between chiropractors. Also when appropriate, relevant information regarding your child's case may be sent to other medical and healthcare practitioners for the proper and effective management of your child's condition.

Guardian's Signature _____ Date _____/_____ /_____

CONSENT FORM

I, as parent/legal guardian, hereby give my consent for my child (below) to receive Chiropractic care.

Child's Name _____ Date_____ /_____/_____

Guardian's Name _____ Signature_____

CLINIC POLICY

We regard your appointment with Amit as important to you and to others who have adjoining appointments.

Patients under 16 years cannot be legally treated without an adult present.
Minors remain the responsibility of parents/guardians whilst on these premises. Children are not to be left unattended.

If you are unable to keep your appointment, the courtesy of 24 hours notice will enable us to schedule someone else in your place. Failure to do so may incur a cancellation fee.
For your convenience, we endeavour to always treat you at your appointed time as we respect the value of your time.
Your co-operation is sincerely appreciated.

Guardian's Signature _____