Institute of Sports and Spines

Initial Child (3-8 years old) Chiropractic Treatment Patient intake form

Title: _____ First Name: _____ Initial: ____ Surname: _____ M ☐ F ☐

Home Address: _____ Suburb: _____ Postcode: _____

D.O.B. ____/___/____ Patients Age_____

Mothers Name:_____ Mobile No: _____

Fathers Name:_____ Mobile No: _____

Siblings Names & Ages:_____

Parents E-mail address:_____

Private Health Fund Member number: _____ID number on card:_____

How did you hear about us? Name : _____

☐ Friend / Relative ☐ Health care provider ☐ Advertisement ☐ Yellow pages ☐ Other: _____

Medical Practitioner's (GP) Name: _____ Phone: _____

Paediatrician (if applicable) Name: _____Phone: _____

What concerns do you have regarding your child's health:_____

Please tick any of the issues/conditions that your child has experienced:

☐ asthma	☐ sinus	☐ over activity
☐ eczema	☐ bed wetting	☐ tantrums
☐ chronic colds	☐ poor sleeping habits	☐ anxiety
☐ recurrent ear infections	☐ fatigue or lethargy	☐ irritability
☐ recurrent tonsillitis	☐ easily distractable	☐ neck pain
☐ digestive disorders	☐ poor memory	☐ headaches
☐ constipation	☐ poor fine motor skills	☐ sore eyes/blurred vision
☐ diarrhea	☐ poor handwriting	☐ joint aches/pains
☐ chest infections	☐ dislike reading	☐ growing pains
☐ recurring fevers	☐ poor co-ordination	☐ scoliosis
☐ seizures or convulsions	☐ unusual walking pattern	☐ frequent days off school
☐ allergies	☐ speech delay	☐ others (please list)
☐ hayfever	☐ travel/motion sickness	

What has caused your child's present condition: _____

How long has he/she had this condition: _____

Does it reoccur: ☐ Yes ☐ No. If so, when and how often? _____

When does it seems worse?: ☐ Morning ☐ Evening ☐ During the night _____

Does the condition wake him/her at night: ☐ Yes ☐ No

Does anything seem to aggravate his/her condition?: ☐ Lying ☐ Sitting ☐ Movement ☐ Other _____

Does anything seem to relieve his/her condition?: ☐ Yes ☐ No If yes, please explain_____

Has he/she had any previous treatment for this condition? ☐ Yes ☐ No

If yes, who provided the treatment? _____

What best describes your babies sleeping pattern?: _____

_____

Medical History:

Please describe any falls or accidents:_____

Please detail any hospitalisations or surgery:_____

Please detail any fractures or dislocations:_____

Please list any disease or illnesses:_____

Please list any current medications:_____

During the last 6 months, please list the number of doses of antibiotics your child has had:_____

During their lifetime how many does of antibiotics has your child had?_____

Is your child vaccinated?: ☐ Yes ☐ No, if yes are they up to date with their vaccinations?: ☐ Yes ☐ No

Other health details:

Is your child under the management of any other health practitioners? ☐ behavioural optometry ☐ podiatry ☐ orthodontics ☐ speech pathology ☐ paediatrician ☐ other_____

Does your child wear/previously been recommended to wear orthotics? ☐ Yes ☐ No

Does your child wear/previously been recommended to wear glasses? ☐ Yes ☐ No

Does your child wear/previously been recommended braces/orthodontic splints? ☐ Yes ☐ No

Additional Information:

Please include any further information here that you feel hasn't been covered on this form that is relevant to your child's health and wellbeing:_____

_____

_____

Please tick this box ☐ if you would prefer to discuss your child's health history behind closed doors whilst your child remains supervised out in the reception area.

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INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care is recognised throughout the world as being an effective and safe method of care for both adults and children for many different conditions. In adults and children the chiropractic adjustment (manipulation) of the spine is acknowledged internationally as being far safer in dealing with neck and low back pain than medication and many other alternatives. (A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993). However as with all health care procedures there is a health risk which you are now required by law to be informed about.

In extremely rare circumstances, some treatments to the neck may give rise to stroke or stroke like symptoms. Studies indicate approximate risk ranges from 1.3 in 100,000 (Rothwell 2001) to 1 in 5.85 million (Haldeman, et al. Spine vol 24-8 1999). Other very slight risks include strain or injury to a ligament or disc in the neck (less than 1 in 139,000) or the lower back (1 in 62,000). (Dvorak study in Principals and Practice of Chiropractic, Haldeman 2nd Ed).

The risks of a child experiencing an adverse reaction to chiropractic care is extremely rare and has been estimated at between 1 in 250 million and 1 in 700 million chiropractic adjustments.

Whilst this has never occurred in this practice, we are still required by law to inform you of these risks.

If you have any questions related to the treatment you are about to receive please speak with the chiropractor. You can choose other alternatives to this treatment, which might include chiropractic without manual adjustment, no treatment, acupuncture or other.....

Chiropractic care consent statement:

1. I have had the opportunity to discuss the proposed care with the treating Chiropractor and I acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed chiropractic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.
2. I also acknowledge the following additional potential risks insofar as my/my child's proposed care is concerned have been explained to me.
3. I acknowledge that I am aware and understand the potential risks. I appreciate that results are not guaranteed.
4. I do not expect the practitioner to be able to be able to anticipate all potential risks and complications associated with the proposed care.
5. I hereby acknowledge my consent to the performance of the proposed chiropractic care by my treating chiropractor and/or any other chiropractor working in this clinic, and the sharing of appropriate information to ensure the highest standard of care. I understand that I can withdraw consent at any time.

Patient Name:_____ Patient Signature: _____Date:_____

Practitioner Name: _____ Practitioner Signature: _____Date:_____