DVD 2 ROF date: Source: Entered Capable: Master list updated:

Child Health History Form

We are happy you have chosen to have your child's spine checked. Many types of stress (physical, mental, and chemical) can interfere with your child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please ask questions!

Child's Name_____ Date of Birth_____
Address_____ Suburb_____ Postcode_____
Home Phone_____ Parent's work phone _____
Mother's Name_____ Father's Name _____
Names and Ages of Siblings _____

Reason for consulting our office
_____
_____
_____

Previous Chiropractic Care? Y / N If yes, with whom? _____
How long was care received? _____ Last Check-up _____

CIRCLE APPROPRIATELY:
Birth Place: Home / Birth Center / Hospital
Type: Natural / C-section
Procedures: Forceps / Vacuum Extraction
Was delivery long: Y / N Was delivery difficult? Y / N Labor Induced? Y / N
Epidural? Y / N Pain Medication? Y / N
Was baby breech/in utero-constraint? Y / N
Was baby breast fed? Y / N Duration_____
Which sports does/did your child participate in?
None / Soccer / Football / Gymnastics / Cheerleading / Karate / Basketball / Dance
Other(s)
_____

According to the National Safety Council, approximately 54% of infants fall head first from a high place (bed, changing table, etc…) during the first year of life. List any other falls or accidents_____
_____

Check any of the following conditions your child has suffered from:
(Circle 'P' if in the distant past, circle 'R' if in the past 6 months)

P / R Ear Infections P / R Scoliosis P / R Seizures
P / R Chronic colds P / R Asthma/Allergies P / R Digestive Problems
P / R Headaches P / R ADD/ADHD P / R Recurring Fevers
P / R Growing/Back Pains P / R Colic P / R Bed Wetting
P / R Constipation P / R Head Banging P / R Other:_____

List date and year of any surgeries or hospitalizations
_____
_____

DVD 2 ROF date: Source: Entered Capable: Master list updated:

WELLBEING CHIROPRACTIC

MEDICATION

How many rounds of antibiotics has your child taken in the last 6 months? _____
Lifetime _____
Present prescription drugs_____
Past prescription drugs_____
Over the counter drugs (past 6 months) _____

FINANCIAL INFORMATION

Person responsible for account: _____

AUTHORISATION FOR CARE OF A MINOR

I hereby authorise Wellbeing Chiropractic and whomever they may designate to administer care, as they deem necessary to my son/daughter.

My presence is / is not necessary for care to be rendered (circle one).

At Wellbeing Chiropractic we are firmly committed to safety and efficacy in clinical practice. Spinal manipulation is a complex clinical skill and should **only** be performed by a suitably qualified professional (i.e. Chiropractic degree or equivalent). We endeavour, through professional conferences, journals and continuing education, to maintain the highest standards of care. As part of a professional standard of care, we feel it is important to discuss **risk.**

In any clinical or medical procedure that deals with people there are inherent risks. Complications of spinal manipulation when performed correctly and appropriately are ***extremely*** low in comparison to any other form of treatment. There is a possibility (figures suggest one chance in two million) that spinal manipulation of the cervical spine (neck) may be associated with damage (major or minor) to the blood supply of the brain (stroke). As an indication of comparative risk there is an accepted figure of sudden death under general anaesthesia of one in ten thousand; death caused by prescription anti-inflammatory drugs is **3,300 times more likely** than spinal manipulation. Other risks associated with spinal manipulation may relate more specifically to your condition or aggravation to the spinal structures themselves such as the bones and ribs (a possibility of fracture) or the discs, ligaments or nerves. The purpose of our physical examination is to assess your condition with these things in mind so that we may choose the most appropriate technique for you. We believe that our expertise and experience enable us to provide the safest possible care. However, we would ask your co-operation in keeping us fully informed of your symptoms, past illnesses and any changes in your medical history including medications.

Comments ……..

If you have ***any*** queries or concerns please feel free to discuss these with us at any time. I have read and understood the above, and that I may choose to have no treatment or alternate treatment for my condition. I hereby consent to chiropractic treatment at Wellbeing Chiropractic**.** I understand that I may withdraw my consent at any stage. I have had the opportunity to discuss this consent form and proposed treatment with the chiropractor.

Signature …… Date...../2015

Name (please print) ……

OFFICE ONLY:

ACT / MAN	

Chiropractor Notes:

X-RAYS - Neck P LBP Cervico-genic HA's Postural abnorm Mid Tx P Hand pain from neck Scoliosis