

WELCOME TO CHIROPRACTIC HEALTH CENTRE YOUR CHILD'S HEALTH PROFILE

2 -15

(Please complete ALL sections)

Your Child's Name:		Date:
Address:	Suburb:	Postcode:
Home Phone:	Parent/Guardian Mobile Phone:	
DOB:	Age:	Email:.....
		<input type="checkbox"/> Tick if you do not wish to receive information by email
Mum's Name	Dad's Name	
Siblings Names and Ages:		
Do you have Private Health Cover? Yes No Which One?		
Your Medicare No:	Exp. Date:	Reference No:
Your child's Previous Chiropractor's Name:		Date of Last Visit:
Who Recommended You To Our Centre?		

**Even babies and young children have experienced many things that could cause spinal misalignments or "Vertebral Subluxations".
Vertebral Subluxation affects your child's nervous system which affects your whole health, resulting in the unwanted conditions babies and children suffer from every day.**

Please describe your child's primary health concerns or reasons for consulting our office:

1. _____ for how long? _____
2. _____ for how long? _____
3. _____ for how long? _____

What do you think caused this problem(s)? _____

Other Doctors you have seen for this condition(s)? _____

Your Child's Birth

How long was the entire labour? How long did you actually push?.....

Were you induced? Yes No Epidural? Yes No C-Section Yes No

Was there any pulling on the head? Yes No Forceps or Vacuum Extraction used? Yes No

Were there any complications before/during/after birth? Please describe

.....

Please tick/circle any of the following symptoms your child has experienced:

- | | | |
|--|---|--|
| <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Allergies / sinus | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Learning Difficulties | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Epilepsy / seizures |
| <input type="checkbox"/> Asthma / Breathing Difficulties | <input type="checkbox"/> Irritability / Moodiness | <input type="checkbox"/> Neck pain / Stiffness |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Depression | <input type="checkbox"/> Numbness/tingling in arms/hands |
| <input type="checkbox"/> Recurrent Colds / Flu | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Dizziness / ringing in ears |
| <input type="checkbox"/> ADHD / Autism / Hyperactivity | <input type="checkbox"/> Weight Problems | <input type="checkbox"/> Pain between shoulders |
| <input type="checkbox"/> Constipation / Diarrhoea | <input type="checkbox"/> Fatigue / Energy Levels | <input type="checkbox"/> Numbness/tingling in legs/feet |
| <input type="checkbox"/> Poor Sleeping Patters | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Bowel / Bladder Problems |
| <input type="checkbox"/> Growing Pains | | |

Your Child's Accident and Trauma History

Did you know 47% of all children fall on their head by the age of one and they have at least 200 more major falls by the age of 5 years old.

Childhood Injuries

Briefly describe your child's most recent falls, slips or incidents.

1. When?..... What happened?
Injuries? Treatment?.....
2. When?..... What happened?
Injuries? Treatment?.....
3. When?..... What happened?
Injuries? Treatment?.....

Sport and Recreation

What sports or recreation does your child enjoy?

Any falls / accidents / injuries during these sports or recreations? Yes No

When? (year) Treatment?

Any broken bones / fractures / reconstructions?.....

Motor Vehicle Accidents (Did you know that the maximum speed to cause Subluxation is only 13km/hr)

Has your child been involved in a motor vehicle accident as a passenger? Yes No

1. When?..... What Speed?..... Impact? *Front side back stationery*
Injuries Treatment?

List ALL surgeries. What year?

List ALL medications you currently take (including vitamins,herbs):.....

Informed Consent

Changes to the law now require all practitioners who adjust the spine to warn patients of material risks. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (approx. 1 in 5.85million)¹. Whilst this has never occurred in this practice, we are still required to warn you.

In other extremely rare circumstances there may be strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (less than 1 in 62,000)².

Chiropractic adjustments of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medication and many other alternatives³.

Should our chiropractor accept your case for chiropractic care and you have any questions related to the treatment you may receive, please contact this office immediately.

1. Neck Manipulations. Haldeman, et al. Spine vol 24-8, 1999 2. Dvorak Study in Principles and Practice of Chiropractic, Haldeman, 2nd Ed
3. A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993.

Based on the information provided I consent to receiving chiropractic care by a registered Chiropractor in this centre, and I acknowledge that I have read and understood the information contained in this document. I understand that I can withdraw my consent at any time.

The above information is true and accurate to the best of my knowledge.

Parent / Guardian Signature :..... Date:.....



Office Use Only
L R.....
<input type="checkbox"/> FHP <input type="checkbox"/> L <input type="checkbox"/> R Pronation <input type="checkbox"/> L <input type="checkbox"/> R VAT
Notes:
.....
.....
R1 Call: