PAEDIATRIC CASE HISTORY

It is a pleasure to welcome you to our family of Chiropractic clients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us care for your child better, please complete the following information. We look forward to working with you.

Name: _____ DOB: _____

Address: _____ Suburb: _____ Postcode: _____

Phone (H) _____ (M) _____ Weight: _____ Height: _____

Email address: _____

Would you like to register for online booking? Y N

☐ Please tick if you *do not* wish to receive a confirmation SMS prior to your appointment.

☐ Please tick if you *do not* wish to receive our newsletter

Names of Parents/Guardians: _____

How did you find out about our practice? Yellow Pages Online Yellow Pages Phonebook Google

Wellspring website Facebook Other: _____

Who may we thank for referring you? _____

Are you covered for extras under a health fund? Yes No Health Fund: _____

Purpose for contacting us: _____

Other Doctors seen for this condition: Y N Name: _____

Please tick any of the following conditions your child has suffered from during the past 6 months:

O Ear Infections	O Digestive Problems	O Car Accident
O Asthma/Allergies	O Bed Wetting	O Chronic Colds
O Colic	O Growing/Back Pains	O Recurring Fevers
O Headaches	O Seizures	O Temper Tantrums
O Scoliosis	O ADHD	O Other: _____

FAMILY HISTORY

Has your child ever received Chiropractic care? Yes No

Previous Chiropractor: _____ Date of Last Visit: _____

Reason: _____

Name of Paediatrician/GP: _____ Date of Last Visit: _____

Reason: _____

Antibiotics – Number of doses your child has taken:

In the last 6 months: _____ Total during lifetime: _____

Prescription Medication – number of doses your child has taken:

In the last 6 months: _____ Total during lifetime: _____

Vaccination History: _____

PRENATAL HISTORY

Name of Obstetrician/Midwife: _____

Complications during pregnancy? Y N _____

Ultrasounds during pregnancy? Y N How many: _____

Medications during pregnancy/delivery? Y N _____

_____

Cigarette/Alcohol use during pregnancy? Y N

Location of Birth: Hospital: _____ Birthing Centre: _____ Other: _____

BIRTH INTERVENTION

O Forceps O Vacuum Extraction O Caesarian Section: O Planned O Emergency

Complications during delivery? Y N _____

Genetic disorders or disabilities? Y N _____

FEEDING HISTORY

Breast Fed? Y N How long? _____

Formula Fed? Y N How long? _____

Introduced to solids at month: _____ Cows Milk at month: _____

Allergies/Intolerance? Y N _____

DEVELOPMENTAL HISTORY

At what age was your child able to:

Respond to sound: _____ Hold head up: _____ Cross crawl: _____ Walk alone: _____

Respond to visual stimulus: _____ Sit up: _____ Stand alone: _____

Has your child had a fall off a bed, changing table, down stairs etc? Y N _____

Has your child been involved in any high impact or contact type sports (i.e. rugby league, soccer, martial arts)? Y N _____

Has your child ever been involved in a car accident? Y N _____

Has your child been seen on an emergency basis? Y N _____

Other traumas not described above? Y N _____

Prior Surgery? Y N _____

CHILDHOOD DISEASES

Chicken Pox: Y N Age: _____

Rubeola: Y N Age: _____

Rubella: Y N Age: _____

Mumps: Y N Age: _____

Whooping cough: Y N Age: _____

Other: Y N Age: _____

How would you currently rate your child's health (if 10 is exceptional and 1 is poor)?

1 2 3 4 5 6 7 8 9 10

Do you have any health goals for your child? _____

_____

We are here to care for you and your family and encourage you to ask questions.
Your participation is vital and will help determine your child's results.

AUTHORISATION FOR CARE OF A MINOR

INFORMED CONSENT

Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks associated with all health care procedures, including assessment and treatment, which you should be informed about. Please read the following carefully:-

1. I acknowledge that I have discussed with my Chiropractor the rare risks associated with my proposed care which include but are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries including disc encroachments/ruptures, causing nerve irritation and referred symptoms, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition. Such risks may result in outcomes such as referral, further tests, surgery, incapacity and the like.
2. I have had the opportunity to discuss the proposed care with my Chiropractor. I also 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.
3. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.
4. I do not expect the practitioner 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 Chiropractor and/or any other chiropractor working in this clinic. I understand that I can withdraw consent at any time.
6. In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (between 1 in 2 million to 1 in 5.85 million -*Haldeman, et al. Spine vol 24-8 1999*). Other possible risks include strain/injury to a ligament or a disc in the neck (less than 1 in 139,000) and the low back (1 in 62,000 - *Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed*.). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible."

If you have any questions related to the chiropractic care you are about to receive or about alternative options, please speak to the chiropractor.

I have discussed the above information with the chiropractor and give my consent to Chiropractic Care.

_____ _____

Client or Guardian's Signature Chiropractor's Signature

_____ _____

Client's Name Date

CONSENT FORM – COLLECTION OF INFORMATION

Wellspring Chiropractic needs to collect information about you for the primary purpose of providing quality treatment. In order to thoroughly assess, diagnose and treat you, we need to collect some personal information from you. If you do not provide this information, we may be unable to treat you. This information will also be used:

- For the administrative purposes of running the practice;
- For billing, either directly or through an insurer or compensation agency;
- Within the practice for handover if another practitioner provides you with care;
- To update your doctor, teacher, specialist, insurer, solicitor or employer on the progress of your care, where they are involved in the management of your health.

We do not disclose your personal information to overseas recipients.

Wellspring Chiropractic has a Privacy Policy that is available on request and in our reception area. The Policy provides guidelines on the collection, use, disclosure and security of your information. It also contains information on how you may request access to, and correction of, your personal information and how you may complain about a breach of your privacy and how we will deal with such a complaint.

I, _____, have read the above information and understand the reasons for the collection of my personal information and the ways in which the information may be used and disclosed and I agree to that use and disclosure.

I understand that it is my choice as to what information I provide and that withholding or falsifying information might act against the best interests of my examination and treatment progress.

I am aware that I can access my personal and treatment information on request in writing, and if necessary, correct information that I believe to be inaccurate.

I understand that if, in exceptional circumstances, access is denied for legitimate purposes, that the reasons for this and possible remedies will be made available to me.

I have been provided with or have been given an opportunity to obtain a copy of Wellspring Chiropractic's Privacy Policy.

Signed:_____ Date:_____