yeronga chiropractic & wellness centre

New Child Patient Questionnaire

Personal Details

Child's Name :	Parents' Names Parent 1 : Parent 2 :		Date:
Address:			
Suburb/Town:			Postcode:
DOB:	Year at school:	Gender:	Ph:
Email:			

Keeping in touch, please confirm the way you would like to be contacted by us: SMS reminders ☐ Email ☐

Referrals

How were you referred to our clinic?

Friend/Family member ☐ If so – Name: _____

Other Health Professional/Chiropractor ☐ If so – Name: _____

Advertising ☐ Internet ☐ If so – Site Name: _____

Spinal Screening ☐ Sign ☐

History

What concerns do you have regarding the health of your child? _____

_____

When did the symptoms start? _____

What makes the symptoms better? _____

What makes the symptoms worse? _____

Are they getting worse? _____

Has this occurred before? Yes ☐ No ☐

How often does this occur? _____

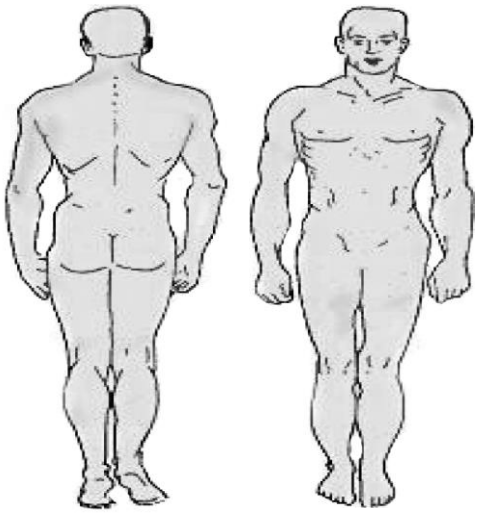
Do you know what caused it? _____

Has your child received any treatment for this condition? If so please list:

_____

Was it effective? Yes ☐ No ☐

Please indicate the area (s) of discomfort on the diagram (on right):



Please indicate the severity of discomfort you are experiencing right now (circle most appropriate):

1 2 3 | 4 5 | 6 7 8 | 9 10

No pain Discomfort Very sore Extreme pain

General Health

A poorly functioning spine and nervous system can affect the way your entire body functions. Is your child experiencing any other health problems, such as:

(Please circle and write 'O'- for occasionally or 'F'- for frequently.)

Neck Pain	Yes ☐	No ☐
Headaches	Yes ☐	No ☐
Shoulder Pain	Yes ☐	No ☐
Mid-Back Pain	Yes ☐	No ☐
Lower-Back Pain	Yes ☐	No ☐
Hip Pain	Yes ☐	No ☐
Knee Pain	Yes ☐	No ☐
Other	Yes ☐	No ☐

If yes to 'Other' please briefly outline: _____

BIRTH

How was your child delivered? (please tick the appropriate box)

Premature	☐	Forceps	☐	Without intervention	☐
Late	☐	Caesarian	☐	Chemically Induced	☐
At Term	☐	Suction	☐	Vacuum or Other	☐

Do you believe the birth was traumatic for the child? Yes ☐ No ☐

Were there any delivery complications? Yes ☐ No ☐

If so please provide details:_____

BIRTH TO SIX MONTHS

Was your child breast fed? Yes ☐ No ☐ For how long? _____

Was your child formula fed? Yes ☐ No ☐ For how long? _____

Did your child suffer Colic/Reflux? Yes ☐ No ☐

Sleeping – would you say your child was: Very poor ☐ Poor ☐ Average ☐ Good ☐ Very Good ☐

General History

Has your child had any significant falls or injuries? Yes ☐ No ☐ _____

Has your child ever been in a motor vehicle accident? Yes ☐ No ☐ _____

Has your child been hospitalized or had surgery? Yes ☐ No ☐ _____

Has your child suffered any significant illness? Yes ☐ No ☐ _____

Is your child on any medication? Please list: Yes ☐ No ☐ _____

From early life to present, have there been any concerns with (please circle condition/s):

Birth (difficult/traumatic/ complications)	Colic/Unsettled Baby	Reflux	Constipation/ Diarrhea	Fever/Nausea	Painful Cough/ Sneeze
Tinnitus/Ringing in Ears	Sleeping	Breastfeeding	Mobility	Flexibility	Muscle Tone
Muscle Weakness	Coordination	Posture	Scoliosis	Schoolwork	Sports Injuries
Double/Blurred Vision	Tingling/ Numbness	Asthma/ Breathing Difficulties	Cold/Painful Extremities	Dizziness/ Loss of Balance	Weight or growth issues

Have you had any concerns regarding your child's development, injuries, or illness during the years of (please tick and briefly outline)

0-1 years of age ☐ _____

1-4 years of age ☐ _____

5-10 years of age ☐ _____

10+ years of age ☐ _____

Do you have any other questions or concerns that you would like to discuss?

_____

_____

Thank you for taking the time to fill out this form.

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Informed Consent to Chiropractic Care

Chiropractic Adjustments (manipulations) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medical and many other alternatives. (A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993.)

Changes to the law now require all practitioners who manipulate 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 2.15 million). Other very slight risks include (but are not limited to) strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000) [Dvorak study in Principles Practice of Chiropractic, Haldeman. 2nd Ed.]

If you have any questions related to the treatment that you are about to receive, please speak to your Chiropractor.

Please do not sign until you have spoken to your Chiropractor.

I acknowledge that I am aware of and understand the potential risks. I have discussed the above information with the Chiropractor and give my consent to treatment.
I understand that results are not guaranteed and that the Chiropractor is not able to anticipate all potential risks and complications associated with the proposed care.
I have had the opportunity to ask questions about the nature, extent and purpose of the proposed Chiropractic care and I have been given sufficient time to make a decision giving consent for the care to proceed.

I intend this consent form to cover the entire course of treatment for my present condition and for any other future condition(s) for which I seek treatment from Yeronga Chiropractic. I understand that I can withdraw my consent at any time.

Please note we have a missed appointment / late cancellation fee of $30. Out of consideration to the practice and to our other patients wanting appointments, please contact us at your earliest convenience should you need to cancel or reschedule your appointment.

Date _____

Patient's Signature _____

Print Name _____

Parent/Guardian Signature _____
(if patient is under 18yrs)

Chiropractor's Signature_____

Dr Aidan McGuigan B.App.Sc (Clinical Science) B.Chiro.Sc

Dr Lucinda Smith B.Sc(Chiro) / M.Chiro