

Name: _____ D.O.B. _____ I.D. _____ Date: _____

Welcome to Connective Chiropractic, Dr Bill Logan and Dr Brandon Doyle.

Please take the time to complete all three of our initial consultation information forms.

CHILD HEALTH HISTORY (Age 3 - 16 years)

Child's first name _____ Surname _____ D.O.B. _____

Primary Carer (Mum/Dad/Grandparent/Carer) _____

Address _____ Suburb _____ Postcode _____

Home/Work Phone _____ Mobile _____

Email _____ (Required for statements/communications)

Secondary Carer (Mum/Dad/Grandparent/Carer) _____

Address _____ Suburb _____ Postcode _____

Home/Work Phone _____ Mobile _____

Email _____ (Required for statements/communications)

Do you have a Private Health Fund with Chiropractic Cover? Yes No If Yes, Name _____

Who may we thank for referring you to our office? _____

Child's GP _____ Address _____

Has your child been to a chiropractor before? Yes No Were x-rays taken? Yes No

Names and ages of siblings _____

(cont/d) _____

List any prescribed medications/drugs your child is currently taking _____

Are you consulting our office for a Spinal check Specific health/spine concern?

Please describe your main area(s) of concern below:

1. _____ Age it started? _____

2. _____ Age it started? _____

Does your child have or experience any of the following conditions?

Heart condition Poor Digestion Hyperactivity

Skin problems Headaches Meningitis

Difficulty breathing/Asthma Sleeping problems Bed wetting

Learning Difficulties Irregular bowel movement Milk/lactose intolerance

Low back pain Fatigue Blood noses

Neck pain Irritability Allergies

Ear/throat infections Sinus problems Growing pains

Primary Carer Signature _____ Date _____

Name: _____ D.O.B. _____ I.D. _____ Date: _____

HEALTH HISTORY

Were there any pre-natal complications?

Was the child born full term? Yes No If no, number of weeks premature

How long was the labour? How was the infant delivered? Vaginal C-Section Forceps Ventouse

Breastfed? Yes No If yes, for how long? _____ months If no, name of formula

Has your child been vaccinated? Yes No If yes, please list:

1. _____ Age _____ 3. _____ Age _____

2. _____ Age _____ 4. _____ Age _____

Has your child ever been hospitalised (other than birth) or had surgery? Yes No

Is your child on medication? Yes No

Has your child ever had any broken bones or sprain injuries? Yes No

Is your child accident prone? Yes No

Has the child had any falls down steps? Yes No

Has your child ever fallen from heights over 2 feet? Yes No

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

Has your child a learning disorder? Yes No

Do you think your child has poor posture? Yes No

Is your child nervous, or has anyone suggested this? Yes No

Please list any known family history that may be relevant

(cont/d)

Who is responsible for payment of the account?

“Everything I have stated above is to the best of my knowledge accurate and true”

Child's Name _____

Primary Carer Name _____

Primary Carer Signature _____ Date _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

Scope of Care: Chiropractic care is focussed on finding and correcting spinal problems that alter the normal spinal shape and movement. Spinal problems may affect the healthy function of the nerves and spinal cord and be detrimental to health. Chiropractors correct spinal problems using forces applied generally by hand or special drop piece tables. These forces made are called adjustments. Chiropractors may use various exercises, traction devices, shoe lifts or specifically prescribed orthotic devices to help the spinal corrections.

Medication: Many patients experience great health improvements beyond spinal improvement and it is common for patients to report changes in medical health conditions,. However, changes in medications or management of medical conditions need to be done by your General Practitioner or specialist. Chiropractors cannot advise you as to your medical needs.

Alternatives to Chiropractic Care: If a patient does not want to improve spinal alignment or function then the alternative is pain relief care with other health professionals or care designed to stabilise the spine such as core exercise.

Risks of Not Undergoing care: Spinal problems may get worse if untreated and may lead to progressive damage of the spinal discs, the spinal nerves, the spinal cord and affect general health.

RISKS TO PATIENTS: All types of care and examinations have associated risks and it is important that a patient accepts these before undergoing examination and any care including adjustments, exercise and/or traction. Adjustments require forces to move spinal bones and as such put stresses on blood vessels, bones, discs, nerves and soft tissues. The below are some of the more serious and more common risks, but it is not an exhaustive list.

- A) **RARE BUT SERIOUS RISKS:** Damage to blood vessels, bones, discs or spinal cord may lead to death, stroke, paralysis or permanent injury.
- B) **MORE COMMON BUT LESS SERIOUS RISKS:** Sprains, strains, rib fractures, bruising inflammation and soreness.

Consent for X-Rays: X-rays are taken when indicated to assess spinal biomechanics and the integrity of osseous and soft tissue structures.

If you have further questions regarding risks of examination or care then please ask the Chiropractor before signing below. Your examination results and recommendations for any care and alternatives to care will be thoroughly discussed in private with the Chiropractor and the assistant.

In signing below you acknowledge that you have been given opportunity to ask further questions about the spinal examination and spinal x-rays.

I, the undersigned, consent to examination, any necessary x-rays and any agreed care for my infant.

CHILD'S NAME _____

PRIMARY CARER'S NAME _____

SIGNATURE _____ **DATE** _____

CHIROPRACTOR'S SIGNATURE _____