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 _____

PARENT INITIALS _____

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** _____

Name:_____ D.O.B. _____ I.D. _____ 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: <u>All types of care and examinations have associated risks</u> 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 _____