

Age to 12 - 17 New Patient Introduction

INCLUDING CONSENT TO TREAT A MINOR

Please Print

Child Patient Name _____ Today's Date _____

Date of Birth; _____ Age: _____

Parent Name(s): _____ Are they the child's guardian? Yes No

If no, name of guardian(s) _____

Names & ages of siblings _____

Address _____ Town/City _____ Postcode _____

Home Ph _____ Business Ph _____ Mobile _____

Who referred you to our clinic? _____ Health Fund _____

Major Complaint _____

How long has this condition existed? _____

Is it getting? Worse Constant Comes/Goes Better

Previous diagnosis/treatment for this condition _____

Other complaints _____

On any medication? _____

List any surgery, accidents or falls _____

Any previous Chiropractic care & when _____ For how long? _____ Date of last Adjustment _____

Any spinal x-rays & when _____ Chiropractic doctor & location _____

Birth Process

Was the delivery long Yes No

Was the delivery difficult Yes No

Forceps / vacuum extraction Yes No

Head bruising Yes No

Caesarean Yes No

Breach Yes No

Induced labour Yes No

Drugs during labour Yes No

Drugs during delivery Yes No

List date of last

Physical examination _____

Blood test _____

Chest X-ray _____

Urine test _____

Name of medical doctor _____

Location _____

As a Baby

Was breastfed Yes No

Was a headbanger Yes No

Fell on head Yes No

Fell down stairs Yes No

For Females Only

When did your last period start?

Are you pregnant? Yes No Maybe

Do you experience painful menses? Yes No

Is your menses irregular? Yes No

Has or does child have problems with

- Bowels Yes No
- Bedwetting Yes No
- Recurrent bladder infections Yes No
- Recurrent throat infections Yes No
- Recurrent ear infections Yes No
- Co-ordination Yes No
- Learning difficulties Yes No
- Attention deficit disorder Yes No
- Sinus Yes No
- Eczema Yes No
- Allergies Yes No
- Restless legs Yes No
- Growing pains Yes No
- Headaches Yes No
- Migraines Yes No
- Moodiness Yes No
- Epilepsy Yes No
- Asthma Yes No

Has the child been treated for

- Diabetes Arthritis
- Thyroid Scarlet Fever
- Rheumatic Fever Cancer
- Tuberculosis Cold Sores
- Anemia Pneumonia
- Diphtheria Stroke
- Mumps Glandular Fever
- Appendicitis Allergies
- Eczema High Blood Pressure
- Measles Attention Deficit Disorder
- Polio Migraines

Psychosocial any recent occurrence

- Depression Yes No
- Death (Family / Friends) Yes No
- Divorce / Separation Yes No
- Family Problems Yes No
- Sleep Disturbances Yes No

Family Health History Many health problems are the result of hereditary spinal weaknesses. This information will give us a better picture of the child's total health. List family members who have had any health problems such as migraines, strokes, heart disease, blood diseases, arthritis, spina bifida etc.

Relationship to Child	Past or Present Health Problems

Consent to treatment and examination of a minor

I hereby authorise Dr. Bernard Connolly and whomever he may designate as his assistants to administer chiropractic care as deemed necessary to my child. I hereby also consent to the performance of a chiropractic assessment by the chiropractor including physical, neurological and orthopaedic tests. This may include reflexes, range of movement and the taking of a series of postural photos and X-rays.

 Name of Child

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that Coast Chiropractic Caboolture will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment to Coast Chiropractic Caboolture at the time of service.

 Signature of Parent (or Guardian)

 Today's Date