Care Chiropractic Qld
Because we care

CHILD INFORMATION FORM

CONFIDENTIAL PATIENT INFORMATION FORM

Master / Mrs / Miss/ Ms / Other: ____ Date:_______________

Surname_________________________First Name________________________ Preferred Name_____________

Postal Address____

Residential Address: ____

Telephone: H______________________Mob:____________________________W:________________________

Date of Birth______________________Age__________Email:____

I have been referred to this office by Dr/Mr/Mrs:_____________________Family/Friend/Social Media/Internet/Other

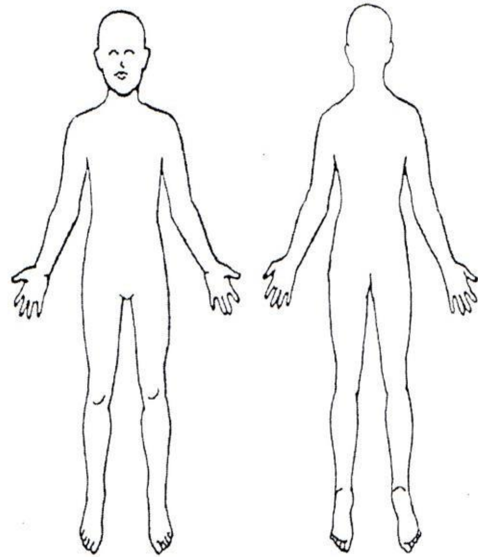
I have had previous chiropractic care by Dr:_________________________in year:_________________________

Emergency contact (if other than partner) Name:_____________________Phone:_________________________

Please tick the following symptoms your child has experienced in the past 12 months:

- O Ear Infections
- O Allergies or Asthma
- O Colic or Digestive Problems
- O Scoliosis (Curvature of the Spine)
- O Bet Wetting
- O Seizures
- O ADHD

Other _____________________



Please mark the areas of concern on the diagram above

Prenatal History

Name of Obstetrician/Midwife: ____

Complications during pregnancy? Y N ________________________________

Medications during Pregnancy/delivery? Y N ________________________________

Cigarette/Alcohol use during pregnancy? Y N

Location of Birth: Hospital: ______________ Birthing Centre: ______________ Home: ______________

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 ____________________

Is/has your child been involved in any high impact or contact type sports (i.e. football, 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 ____________________

What are your health goals for your Child?

O Symptom relief only
O Symptom relief & correction of their underlying cause
O Optimal health of the spine & body now & in the future

Consent for Chiropractic Care

Doctors of Chiropractic, who use manual techniques such as spinal adjustments, are required to advise patients that there are some risks associated with such care. While rare, it has been documented that some patients have experienced the following complications following a spinal adjustment: general soreness/stiffness, muscle strain, ligament sprains, osteoporotic rib fractures and disc injury (less than 1 in 3.7 million) [1]. Current research surrounding the issue of stroke and chiropractic care has demonstrated that there is no evidence of excess risk of injury to the vertebrobasilar artery in comparison to visiting your medical doctor or another primary care provider[2]. The safety record for chiropractors adjusting children is excellent

When delivered by a registered chiropractor, the risk of injury or complications from an adjustment is substantially lower than those associated with many medications and procedures used for similar conditions. Your chiropractor will conduct a thorough examination to determine the most appropriate procedure for your child. All of our chiropractors have received specialty training in the field of pediatrics.

Posture photos may be taken of your child and are for clinical and identification purposes only.

Should you wish to discuss this consent clause further with the chiropractor, please inform the Front Desk staff.

[ ] I consent to chiropractic care for my child as recommended to me by my chiropractor, including spinal adjustments & associated advice. I intend this consent to apply to my child's present and all future chiropractic care.

[ ] I consent to be contacted via email for Appointment Reminders, Workshop Announcements and Educational Material purposes. Care Chiropractic Queensland will not, in any circumstance, share your personal information with other individuals or third party organisations without your permission, except when applicable by law.

1. Drew Olphant (2004) *Safety of Spinal Manipulation in the Treatment of Lumbar Disk Herniation: A Systematic Review & Risk Assessment*, JMPT 27(V3): 197-210
2. Cassidy JD, Boyle, E, Cote et al (2008) *Risk of Vertebrobasilar Stroke & Chiropractic Care: Results of a Population-Based Case-Control & Case-Crossover Study,* Spine 33(4S): S176-183

Date:____

Parent/Guardian's Signature:________________________________

Chiropractors Signature:________________________________