

Dr Nick Chiropractic

Child New Patient Form



Child First Name: _____ Surname: _____

Known as: _____

Mother's / Father's Name(s) _____

Address: _____ Post Code: _____

Email: _____

Phone (home): _____ (mobile): _____

Date of Birth: «DOB» ____/____/____ Age: _____

How referred you to us? _____

When did your child last see a Chiropractor? _____ Who? _____

GP / Specialist _____

Main areas of concern

My child is healthy – we are here for a checkup

Please describe: _____

Age when the problem started. _____

What caused it? _____

On a scale of "0" being nothing and "10" being severe, how would you rate the problem?

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Is the problem constant/ occasional/ weekly/ monthly/ other? _____

What previous treatment have you had? _____

What makes the problem better? _____

What makes the problem worse? _____

Birth

List any pre-natal complications: _____

How long was labor? _____ APGARs _____

How was your child delivered (please circle): Vaginal / C-section / Forceps / Vacuum

Weight at birth _____ kg



Development / Current

- How is your baby gaining weight and height? normally / under / accelerated
- Does your baby suffer from any neck stiffness, fever or headaches? YES / NO
- Have you noticed any changes in your baby's alertness (e.g. drowsiness, loss of consciousness)? YES / NO
- Have you noticed any muscle weakness (floppiness) with your baby? YES / NO

How is your child eating and sleeping?

Feeding/ Eating:	Heavy	Moderate	Light	None
Sleeping:	Heavy	Moderate	Light	None

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

Heart condition	YES / NO	Poor circulation	YES / NO
Skin problems	YES / NO	Irregular bowel movements	YES / NO
Hormonal problems	YES / NO	High or Low blood pressure	YES / NO
Difficulty breathing	YES / NO	Changes in normal awareness	YES / NO
Difficulty learning	YES / NO	Changes in hand/feet temperature	YES / NO
Accelerated pulse	YES / NO	Changes in normal strength	YES / NO
Poor digestion	YES / NO	Changes in balance or coordination	YES / NO

Traumas

Has your baby had any accidents or other traumas? (Car accidents, big falls, birth, etc)

Trauma	Age	Severity (at the time) 0-10

General Health History

Has your baby ever been hospitalized? If so, for what? _____

List any surgery with dates: _____

List any allergies _____

Vaccinations your baby has had _____

List any medications or supplements you baby is currently taking _____

List any babyhood illnesses of the parents _____

List any major diseases of the parents _____

List any family history diseases _____

Informed Consent for Chiropractic Care



Scope of care: Chiropractic care is focused 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 exercise, traction devices, shoe lifts or other 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 GP or specialist. Chiropractors cannot advise you as to your medical needs.

Alternatives to Chiropractic Care: If a patient does not wish to correct the spinal alignment and function then the alternatives are pain relief care or care designed to stabilise the spine such as core exercise.

Risks of Not Undergoing Care: Spinal problems may get worse if uncorrected or not managed and may lead to progressive damage of the spinal discs, the spinal nerves, the spinal cord and even general health.

Risks to Patients: All types of care have associated risks and it is important that a patient accepts these before undergoing care. Adjustments require forces to move spinal bones and as such put stresses on blood vessels, bones, discs, nerves and soft tissues. 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 the blood vessels, bones, discs or spinal cord may lead to death, stroke, paralysis or permanent injury.
- b) More common but far less serious: Sprains, strains, rib fractures, bruising, inflammation and soreness.

Pregnancy Release: X-rays can be hazardous to an unborn child. In signing below I consent to x-rays evaluation and certify (if female) that to the best of my knowledge my child is not pregnant.

The Chiropractor has gone through the risks of care and examination. I have been informed of the alternatives to care to my satisfaction. I have had the opportunity to ask any further questions or information from the Chiropractor or to ask for more time before signing the consent to care and examination.

Patient Name: _____

Signed by: _____ (Legal Guardian Name)

Signature: _____

Date: _____

Chiropractor: _____

Signature: _____

Date: _____