CHILD'S FIRST CHIROPRACTIC VISIT

Name of Child: ____

Parent / guardian name(s): ____

Child's Date of Birth: _ _ / _ _ / _ _ Gender: Male ☐ Female ☐

Address: ____

Street # *Street Name* *Suburb* *Postcode*

Contact details:

Mobile Ph: ____________________ Home Ph: ____________________

Work Ph: ____________________ Email: ____________________

What concerns do you have regarding your child's health?

____

____

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Regarding your pregnancy did you (please tick):

Have any difficulties conceiving?		Any miscarriages?	
Exercise?		Have any emotional upsets?	
Smoke or drink?		Have a healthy diet?	
Have any falls?		Take any medications?	
Have any accidents?		Suffer morning sickness?	

Birth details can give vital clues as to potential spinal problems. Was your child delivered normally? Yes / No Please circle:

Posterior	Breach	Induced
Forceps	Suction/Vacuum	Caesarean
Premature	Term	Late

Were any drugs used in the birth? ____

Was the birth difficult or long? Yes / No ____________________________________

Do you believe the birth was traumatic for your child? Yes / No

Apgar scores: 1min ____________ 5min _____________

Was your child's head misshapen at birth? Yes / No Bruised? Yes / No

Were there any complications? Yes / No ___________________________________

BIRTH TO SIX MONTHS - was your baby (please circle):

Breast Fed? Yes / No For how long? ______

Right & left breast evenly? Yes / No Formula fed? Yes / No

From what age? ______ For how long?______

Was/is your baby 'colicky'? Yes / No Mild / Moderate / Severe

Did/does your baby have reflux? Yes / No 'Silent' reflux? Yes / No

How does your baby sleep? Poor / Fair / Good / Excellent

Did/does your baby move his/her bowels daily? Yes / No Easily? Yes / No

Was/is your baby very irritable or unsettled? Yes / No

Are you concerned about the shape of your baby's head? ________________

Has your baby had any reactions to vaccinations _________________________

OTHER PROBLEMS - does or has your child ever experienced (please circle):

Constipation	Diarrhoea	Hyperactivity	Attention difficulties	Social problems
Concentration problems	Learning difficulties	Behavioural problems	Seem uncoordinated	Recurrent colds/flu
Ear aches	Ear infections	Asthma	Allergies	Poor appetite
Lower back pain	Mid back pain	Neck pain	Growing pains	Joint problems
Headaches	Sinus problems	Convulsions	Bed wetting	Scoliosis
Recurrent chest infections	Recurrent tonsillitis	Chronic fatigue		

When did your child roll? __________ Sit______________

Did your child crawl? Yes / No What age? ______________________

When did your child walk? ____

Has your child been to hospital for any reason? _______________________

Has your child had any significant falls/accidents? ____________________

____

Has your child broken any bones? ___________________________________

How many courses of antibiotics has your child had?

In the last 6 months______________ During their lifetime ______________

Has your child had other prescription medication?

In the last 6 months___________ During their lifetime______________

How would you describe your child's eating habits?

Excellent / Good / Fair / Poor / Terrible

Is there anything else you would like the Chiropractor know about your child or his/her family?

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PRIVACY POLICY STATEMENT

In accordance with the new Privacy Act, all information relative to your case is held in total confidence. However, your consent is necessary to allow us to exchange information between chiropractors within this clinic. Also when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

Guardian's Signature: ___________________________ Date: ____________________

PATIENT INFORMATION

When performed by a qualified chiropractor, spinal manipulation is an effective and safe method of treatment for many painful conditions.
There is however risks associated with any treatment, and I am required to inform you of these, even though there has never been a case in this clinic (other than post-treatment muscle and joint soreness).
Please Read the following carefully and write down any questions you may have.

I hereby request and consent to the performance of chiropractic treatment on my child by Dr. Rebecca Hewitt and/or any other chiropractor working in this clinic authorised by Dr. Rebecca Hewitt.

I have had the opportunity to discuss with Dr. Rebecca Hewitt the nature and purpose of Chiropractic treatment.

I understand that results are not guaranteed.

I understand, and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle and joint soreness, muscle strains, joint sprains, fractures, disc injuries, nerve injuries, stroke and stroke-like episodes.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the treatment, which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read the above and I have also had the opportunity to ask questions about its content.

I intend this consent form to cover the entire course of treatment for my child's present condition, and for any future condition(s) for which I seek treatment. I understand that I can withdraw my consent for my child at any time.

Parent / Guardian's signature: ____________________________

Print Name here: ____

Relationship to child: _____________________________________

Child’s name: ____

Date: ______________________________

Chiropractor’s signature: _________________________________

CONSENT TO TREATMENT AND EXAMINATION OF A MINOR

I hereby authorise Dr Rebecca Hewitt and whomever she may designate as her 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.

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Name of Child