yeronga chiropractic & wellness centre

New Child Patient Questionnaire (6yrs +)

Personal Details

Child's Name:	Parent Names Parent 1: Parent 2:	Date:
Address:		
Suburb/Town:		Post Code:
Date of Birth:	Year at School:	Gender:
Parent's Phone:	Email:	
Regular GP/ Paediatrician Details:		
Keeping in touch. Please confirm the way you would like to be contacted by us: ☐ SMS ☐ Email		

Referrals

How were you referred to our clinic?

☐ Friend/family member — If so – Name:

☐ Other health professional/Chiropractor — If so – Name:

☐ Internet ☐ Signage

☐ Spinal Screening ☐ Advertising

History

What concerns do you have regarding the health of your child?

When did the symptoms start?

What makes the symptoms better?

What makes the symptoms worse?

Are they getting worse? ☐ Yes ☐ No

Has this occurred before? ☐ Yes ☐ No

How often does this occur?

Do you know what caused it?

Has your child received any treatment for this condition? If so, please list:

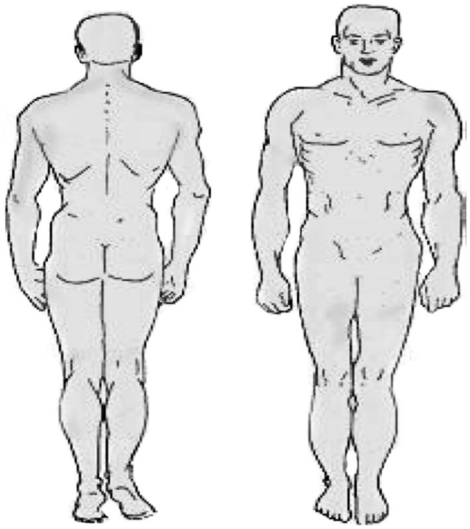
Was it effective? ☐ Yes ☐ No

Please indicate the area(s) of discomfort on the diagram (on right)

Please indicate the severity of discomfort your child is experiencing right now:

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No Pain — Discomfort — Very Sore — Extreme Pain



General Health

A poorly functioning spine and nervous system can affect the way your entire body functions. Is your child experiencing any other health problems:

(If applicable, please tick 'O' – for occasionally or 'F' – frequently)

Neck pain	☐ O	☐ F
Headaches	☐ O	☐ F
Shoulder pain	☐ O	☐ F
Mid-back pain	☐ O	☐ F
Lower-back pain	☐ O	☐ F
Hip pain	☐ O	☐ F
Knee pain	☐ O	☐ F
Other	☐ O	☐ F

If yes to 'Other' please briefly outline

General History

Has your child had any significant falls of injuries?	☐ Yes	☐ No	
Has your child ever been in a motor vehicle accident?	☐ Yes	☐ No	
Has your child been hospitalised or had surgery?	☐ Yes	☐ No	
Has your child suffered any significant illnesses?	☐ Yes	☐ No	
Is your child on any medication? Please list	☐ Yes	☐ No	

From early life to present, have there been any concerns with (please tick condition/s):

☐ Tinnitus/ringing in ears	☐ Sleeping	☐ Reflux	☐ Constipation/diarrhoea	☐ Fever/nausea
☐ Muscle weakness	☐ Coordination	☐ Posture	☐ Mobility	☐ Flexibility
☐ Double/blurred vision	☐ Tingling/numbness	☐ Asthma/breathing difficulties	☐ Scoliosis	☐ School work
☐ Painful cough/sneeze	☐ Muscle tone	☐ Sport injuries	☐ Cold/painful extremities	☐ Dizziness/loss of balance
☐ Weight or growth issues	☐ Other:			

Have you had any concerns regarding your child's development, injuries or illness during the years of:
(please tick and briefly outline)

☐ 0-6 years of age	
☐ 6-10 years of age	
☐ 10-13 years of age	

Do you have any other questions or concerns that you would like to discuss?

Thank you for taking the time to fill out this form

Informed Consent to Chiropractic Care

As with any health care physical examination and/or care provided support there is a risk (however small) of a condition changing or an adverse outcome from the treatment. Recent evidence has demonstrated that no serious adverse events have been reported in association with chiropractic care since 1992, and no deaths from paediatric chiropractic care has ever been reported (Todd et al., 2015).

Chiropractic Adjustments (manipulations) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medical and many other alternatives. (A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993.)

Changes to the law now require all practitioners who manipulate the spine to warn patients of material risks. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (approx. 1 in 2.15 million). Other very slight risks include (but are not limited to) strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000) [Dvorak study in Principles Practice of Chiropractic, Haldeman. 2nd Ed.]

If you have any questions related to the treatment your child may receive, please speak to your chiropractor.

I acknowledge that I am aware of and understand the potential risks. I have discussed the above information with the treating chiropractor and give my consent for treatment to be provided to my child. I understand that results are not guaranteed and that the chiropractor is not able to anticipate all potential risks and complications associated with the proposed care.

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

Please note we have a missed appointment / late cancellation fee of $30. Out of consideration to the practice and to our other patients wanting appointments, please contact us at your earliest convenience should you need to cancel or reschedule your appointment.

Please do not sign until you have spoken to your Chiropractor.

Date:	
Parent/Guardian Name:	
Parent/Guardian Signature:	
Chiropractor's Signature:	

Dr Aidan McGuigan B.App.Sc (Clinical Science) B.Chiro.Sc

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