**INCLUDING CONSENT TO TREAT A MINOR**

Please Print

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| Child Patient Name | Today’s Date | |
| Date of Birth; | Age: |  |
| Parent Name(s): | Are they the child’s guardian? o Yes o No | |
| If no, name of guardian(s) |  |  |
| Names & ages of siblings |  |  |
| Address | Town/City | Postcode |
| Home Ph | Business Ph | Mobile |
| Health Fund |  |  |
| Who referred you to our clinic? | o Friend or Acquaintance (name): |  |
|  | o Family member (name): |  |
|  | o Another Health Professional(please specify) |  |
|  | o Our Signage |  |
| o Yellow Pages  *Online*  *Print* o Website | | |
| o Advertising o Facebook | | |
| o Location o Natural Therapy Pages | | |
|  | o Other (please specify): |  |
| Major Complaint |  |  |
| How long has this condition existed? | | |
| Is it getting? o Worse o Constant o Comes/Goes o Better | | |
| Previous diagnosis/treatment for this condition | | |
| Other complaints |  |  |
| On any medication/Supplements? | | |
| 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 | |
| Does your child play sport? | How many times per week? | |

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| **Birth Process** |  | **List date of last** |
| Was the delivery long | o Yes o No | Physical examination |
| Was the delivery difficult | o Yes o No | Blood test |
| Forceps / vacuum extraction | o Yes o No | Chest X-ray |
| Head bruising | o Yes o No | Urine test |
| Caesarean | o Yes o No |  |
| Breach | o Yes o No | Name of medical doctor |
| Induced labour | o Yes o No | Location |
| Drugs during labour | o Yes o No |  |
| Drugs during delivery | o Yes o No |  |
| **As a Baby** |  | **For Females Only** |
| Was breastfed | o Yes o No | When did your last period start? |
| Was a headbanger | o Yes o No | Are you pregnant? o Yes o No o Maybe |
| Fell on head | o Yes o No | Do you experience painful menses? o Yes o No |
| Fell down stairs | o Yes o No | Is your menses irregular? o Yes o No |

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| **Has or does child have problems with** | | **Has the child been treated for** | | |  |
| Bowels | o Yes o No | o | Diabetes | o | Arthritis |
| Bedwetting | o Yes o No | o | Thyroid | o | Scarlet Fever |
| Recurrent bladder infections | o Yes o No | o | Rheumatic Fever | o | Cancer |
| Recurrent throat infections | o Yes o No | o | Tuberculosis | o | Cold Sores |
| Recurrent ear infections | o Yes o No | o | Anemia | o | Pneumonia |
| Co-ordination | o Yes o No | o | Diptheria | o | Stroke |
| Learning difficulties | o Yes o No | o | Mumps | o | Glandular Fever |
| Attention deficit disorder | o Yes o No | o | Appendicitis | o | Allergies |
| Sinus | o Yes o No | o | Eczema | o | High Blood Pressure |
| Eczema | o Yes o No | o | Measles | o | Attention Deficit Disorder |
| Allergies | o Yes o No | o | Polio | o | Migraines |
| Restless legs | o Yes o No |  |  |  |  |
| Growing pains | o Yes o No | **Psychosocial any recent occurrence** | | |  |
| Headaches | o Yes o No | Depression | | o Yes o No | |
| Migraines | o Yes o No | Death (Family / Friends) | | o Yes o No | |
| Moodiness | o Yes o No | Divorce / Separation | | o Yes o No | |
| Epilepsy | o Yes o No | Family Problems | | o Yes o No | |
| Asthma | o Yes o No | Sleep Disturbances | | o Yes o 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.

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| Relationship to Child | Past or Present Health Problems |
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Signature of Chiropractor

**CONSENT TO TREATMENT AND EXAMINATION OF A MINOR**

I hereby authorise the doctors at Banks & Dade Family Chiropractic and whomever they may designate as their 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 Banks & Dade Family Chiropractic 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 Banks & Dade Family Chiropractic at the time of service.

Signature of Parent (or Guardian)

Today’s Date