New Patient Registration
Age 0 - 9

Banks and Dade
CHIRO + WELLNESS

INCLUDING CONSENT TO TREAT A MINOR

Please Print

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

Email Address of Parents

Who referred you to our clinic?

1. Major Complaint

How long has this condition existed?

Is it getting? o Worse o Constant o Comes/Goes o Better

2. Major Complaint

Is it getting? o Worse o Constant o Comes/Goes o Better

3. Any other concerns

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?

1. How many times per week?

2. How many times per week?

Please list your child's current or recent medications including supplements

54 The Lakes Way Forster NSW 2428 P: 02 6557 6333 E: info@banksanddade.com.au
www.banksanddade.com.au

New Patient Registration
Age 0 - 9

Banks and Dade
CHIRO + WELLNESS

Birth Process

Was the delivery long	o Yes	o No
Was the delivery difficult	o Yes	o No
Forceps / vacuum extraction	o Yes	o No
Caesarean	o Yes	o No
Breech	o Yes	o No
Induced labour	o Yes	o No
Drugs during labour	o Yes	o No

As a Baby

Was breastfed	o Yes	o No
Was bottle fed breast milk	o Yes	o No
Was bottle fed formula	o Yes	o No
Did they favour a particular side	o Yes	o No

Explain -

Name of medical doctor

Location

Medicare #

Has your child been vaccinated o Yes o No

Has there been any reactions to any prescribed medication or vaccination? Explain

Has your child had any surgeries/ accidents?
Explain -

Has your child had any other diagnosed medical conditions or illnesses? Eg Glandular fever, migraines, cold sores etc
Explain -

Has or does child have problems with

Bowels (constipation, diarrhea)	o Yes	o No
Bedwetting	o Yes	o No
Recurrent bladder infections	o Yes	o No
Headaches /Migraine	o Yes	o No
Co-ordination	o Yes	o No
Learning difficulties	o Yes	o No
Attention deficit disorder	o Yes	o No
Sinus	o Yes	o No
Eczema / Asthma	o Yes	o No
Heart / Lung	o Yes	o No

When did your child meet the following milestones?

Roll	months
Crawl	months
Sit	months
First Words	months
Walk	months

Were there any concerns? o Yes o No

Explain?

Psychosocial: Any recent occurrence of

Depression / Anxiety	o Yes	o No
Death (Family / Friends)	o Yes	o No
Divorce / Separation	o Yes	o No
Family Problems	o Yes	o No

Explain:

Any other stressors? (School, bullies, sport etc) o Yes o No

Explain -

Does your child have any settling/ sleeping issues? o Yes o No

Explain

54 The Lakes Way Forster NSW 2428 P: 02 6557 6333 E: info@banksanddade.com.au
www.banksanddade.com.au

New Patient Registration
Age 0 - 9

Banks and Dade
CHIRO + WELLNESS

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.

Relationship to Child	Past or Present Health Problems

54 The Lakes Way Forster NSW 2428 P: 02 6557 6333 E: info@banksanddade.com.au
www.banksanddade.com.au

Risks Associated with Chiropractic Procedures Form

Please read this form. Your Chiropractor will discuss it with you and ask you to sign a 'Consent to Chiropractic Care Form' prior to any treatment being given.

Your Chiropractor will discuss details of your diagnosis and management of your condition. You are encouraged to ask questions about the treatment proposed, terminology used or treatment options available to you.

Chiropractic treatment, including spinal manipulation or adjustment, has been the subject of many government reports as well as multi-disciplinary studies. Chiropractic has been shown to be a safe, effective treatment for spinal pain, some headaches and similar symptoms.

The risk of injuries or complications from chiropractic treatment is lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms. The purpose of this document is to provide you with the information necessary to consent to treatment, including spinal manipulation.

Possible Adverse Outcomes:

1. In a minority of cases, treatment may not be successful and you may be in the same position you are in now.

2. Uncommonly, your condition may become worse:
   - About 1 in 3 patients may report temporary soreness, tenderness/bruising
   - Some patients report fatigue, headache, dizziness or nausea following treatment. These symptoms usually resolve within 24 hours after treatment.
   - While rare, some patients have reported rib pain, shoulder pain, chest pain and knee pain following manipulation. These symptoms usually resolve within 2 days after treatment.
   - There is a slight risk of other injuries including strain/sprain to a ligament or disc in the neck or lower back. These are rare but can cause nerve pain with radiation of pain into arms, trunk or legs (current statistics neck less than 1 in 139,000 and the low back 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.). Bowel or bladder function can be affected and erectile disfunction has been reported very rarely.
   - In the case of manipulation or adjustment of the neck, there have been reported cases of injury to arteries in the neck. These are very rare events (current statistics between 1 in 2 million to 1 in 5.85 million -Haldeman, et al. Spine vol 24-8 1999). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible.

3. Although we have asked screening questions and performed screening tests, there is no way of guaranteeing that you will not suffer one of these extreme rare events.

4. If imaging is required, it is generally understood that no x-ray exposure is without some risk; however, there is no conclusive evidence of radiation causing harm at the levels you would receive from this proposed diagnostic x-ray exam. Although high doses of radiation are linked to an increased long term risk of cancer, the effects of the low doses of radiation (ie, less than your yearly exposure to natural background radiation) used in diagnostic imaging are not known. Any proposed examination would have been determined clinically necessary as part of your care and every precaution is taken to ensure the lowest radiation exposure is applied to achieve the clinical purpose.

5. If you experience any unexpected signs or symptoms after treatment such as nausea, vomiting, visual disturbances, difficulty speaking or balance problems, please seek medical attention immediately. During office hours, please call the clinic.

Please direct any questions to your treating Chiropractor

CONSENT TO CHIROPRACTIC CARE FORM

I,

_____

Patient Name – please print

have consulted _____

Chiropractor's Name – please print

With the following: _____

Presenting complaint (s)

I have been advised that appropriate management may include the following:

Chiropractic Manipulative Therapy (CMT) *Circle region: Cervical /Thoracic /Lumbo-pelvic/Full Spine.* *Extremity: list ……*	☐	**Soft Tissue Therapy** *(Circle: instrument assisted / myotherapy / muscle stretches / trigger point release / vibration or percussion instruments*	☐
Mobilisations/Traction/Flexion Distraction/Drop piece / Gravitational blocking /Activator *Circle region: Cervical /Thoracic /Lumbo-pelvic/Full Spine.* *Extremity: list ……*	☐	**Low level Laser Therapy**	☐
Neuro-emotional Technique or other emotional treatment	☐	**Rehabilitation exercises** (incl. core strengthening, dynamic stabilization, postural re-training, balance and proprioception training)	☐
Other treatment modality: ……	☐	**Active lifestyle advice** (reassurance, diet, exercise, supplementation.) ……	☐
I do NOT consent to the following treatment:			

- I acknowledge that the treatment modalities I give consent to above, may be administered by any Chiropractor in this clinic that I choose to see.
- I have had the opportunity to discuss the diagnosis, nature and purpose of Chiropractic management with my Chiropractor.
- I have been advised of alternatives and options to me including that of receiving no treatment.
- I have read and discussed the accompanying "Risks Associated with Chiropractic Care form over leaf, in particular those risks that are relevant to my case.
- I have had explained to me any terms in the "Risks Associated with Chiropractic Care" form that I did not understand.

These terms (if any) were: ……

I understand the nature and extent of the risks and I voluntarily accept all risks involved. I also understand that I can qualify or withdraw my consent at any time. This consent does not prevent me seeking damages for injury caused by negligent treatment.

Patient's Signature (or legal guardian): _____ Date: _____/_____/_____

Chiropractor's Signature: _____Date: _____/_____/_____