Welcome to Body & Brain Centre!

Date: ________________

Patient Name: ___________________________________ **DOB:** ________________ **Age:** ________

Mum's Name: ____________________________ **Dad's Name:** ______________________________

Siblings' Names & Ages: ____

Address: __________________________________ **Suburb:** ______________ **Postcode:** ________

Mum's Mobile: _______________ **Dad's Mobile:** ______________ Please call ❐ mum / ❐ dad first

Email Address: ____
Please Tick: ❐ I would like to receive newsletters with special offers, health tips and more.

Who can we thank for referring you? __________________ PS they will get a thank-you voucher

If online, what search words were used? ____

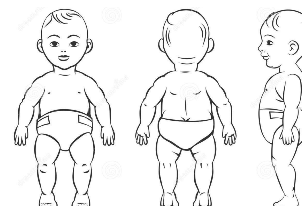
Has your child had previous care from ❐ Chiropractor ❐ Physiotherapist ❐ Speech Pathology ❐ Occupational Therapist ❐ Psychologist ❐ Paediatrician

For What: ____

Please describe your present condition/s, how and when it started & mark on the diagram (if relevant):

____

____



Pregnancy

Did You / the Mother Experience Any: ❐ Falls ❐ Accidents ❐ Significant emotional stress
❐ Illness (Ectopic Pregnancy, Gestational Diabetes, High Blood Pressure, Placenta Previa, etc)
❐ Morning Sickness / Hyperemesis Gravidarum ❐ Exposure to Toxins (Alcohol, Drugs, Tobacco)
❐ Fears about Health / Survival of your Child ❐ Back or Pelvic Pain / Discomfort ❐ X-Rays Taken
❐ Ultrasound performed (how many? _____) ❐ Good health
Details / Other: ____

Supplements / Medication Taken: ____________________________________ ❐ Prenatal Vitamin

Total Number of Pregnancies: _____
Complications in previous pregnancies? ____

Birth

How long was the labour? From first contraction until birth _____________ **Push time?** ________

How Many Weeks? _____________ **Birth Weight:** _____________ **Birth Length:** _____________

APGAR Score: 1 Minute: _______ **5 Minutes:** _______ ❐ Unknown ❐ Unknown except it was low

How was your Child Delivered? ❐ Vaginal ❐ Caesarian (planned) ❐ Caesarean (emergency)

How did your Child Present? ❐ Crown / Top of Head First ❐ Face First ❐ Breach ❐ Other (detail)

Were any Interventions Used? ❐ Epidural ❐ Induction ❐ Forceps ❐ Suction ❐ Other (detail)

Did your child experience: ❐ intensive care unit (NICU) ❐ Resuscitation ❐ Misshapen head

Details: ____

Do you believe the birth process was traumatic for your child? ______________________

Infant History

Was the Child Breastfeed? ❐ No ❐ Yes currently ❐ Yes previously **For How Long?** _________

Is Your Child Currently On Formula? ❐ Yes ❐ No **If so, What One?**_________________________

Age when solids were introduced? ___________ **Any dietary requirements?** _______________

At What Age Did Your Child:

_______	Respond to Sound	_______	Vocalise Noises	_______	Crawl
_______	Follow Object with Eyes	_______	Sit Assisted (eg: in highchair)	_______	Walk
_______	Hold Head Up	_______	Sit Alone	_______	Say mamma / dada

Overall Health

Has Your Child Had or Having Problems with:

Past	Current	N/A		Past	Current	N/A	
❐	❐	❐	Bowels	❐	❐	❐	Eczema / Skin Conditions
❐	❐	❐	Breastfeeding Difficulties	❐	❐	❐	Allergies / Intolerances
❐	❐	❐	Convulsions, seizures	❐	❐	❐	Poor sleep (provide details)
❐	❐	❐	Recurrent Bladder Infections	❐	❐	❐	Sensitivity to Light, Touch, Noises
❐	❐	❐	Recurrent Throat Infections	❐	❐	❐	Colic
❐	❐	❐	Recurrent Ear Infections	❐	❐	❐	Moodiness
❐	❐	❐	Reflux	❐	❐	❐	Sinus
❐	❐	❐	Co-Ordination / Movement	❐	❐	❐	Flat Head (Plagiocephaly)
❐	❐	❐	Epilepsy / Seizures	❐	❐	❐	Torticollis / Twisted Neck

Has your child had antibiotics? ❐ No ❐ Yes **Number of times:** ______ **Reason:** _____________

What is your Child's Hobbies and Interests? ____

The National Safety Council states that approximately 54% of infants fall head first from a high place (bed, changing tablet, etc) during their first year of life.
Has Your Child Experienced Any: ❐ Falls ❐ Accidents ❐ Fractures / Dislocation ❐ Surgeries ❐ Significant Hardship / Stress **and When They Occurred**
Details: ____

____

Has Your Child Been Diagnosed with any Condition, Disorder or Disability Not Previously Mentioned? ____

Please List Your Child's Medications (including Supplements) - current & previous:

____

Is Your Child Up to Date with Their Vaccinations? ❐ Yes ❐ No

Is there a <u>Family History</u> of any Major or Recurring Illness / Diseases?_______________

____

____

Informed Consent For Chiropractic Examination and Treatment

Your child's individualised chiropractic consultations may consist of the following:

1. **Physical Examination:** The examination, prior to any treatment, may exacerbate your child's condition or cause some fussiness.

2. **Gentle non-trust mobilisations of the spine, extremities (arms & legs) or cranium:** Gentle pressure or stretches may be used to relieve tension and promote normal movement patterns. Rarely mild adverse reactions occur (0.53 - 1%) including irritability or soreness lasting less than 24 hours.

3. **Home exercises:** Overdoing or using incorrect technique may result in an exacerbation of your child's symptoms or cause fatigue. Always ask if unsure of any home advice.

4. **Taping:** Sometimes result in skin irritation, minor discomfort or infrequently, an allergic reaction.

5. **Supplements and / or dietary advice:** Gastrointestinal discomfort or disturbances (constipation, diarrhoea), skin rash and potential for drug interactions.
   You are under no obligation to purchase supplements through BCC. We offer carefully selected products which are high in quality active ingredients for your convenience.

Other treatment options include, but is not limited to, pharmacological interventions, surgery, bracing / rest or management with other manual therapists. Adherent risks include, but is not limited to, irritation of the stomach, liver or kidneys and dependance issues to medication; and infection, adverse reactions to anaesthetic or extended recovery times after surgery or hospitalisation. Please discuss these options with your treating practitioner and / or general practitioner for more information.

The risk of remaining untreated or delaying treatment include developing long term musculoskeletal complications, pain or prolonging development of the nervous system. An immature nervous system can have effects on how a child learns, socialises and moves.

Research studies and presentations are performed from time to time within BBC. This assists us deliver the best quality care and to educate fellow practitioners. All information which identifies you will be remove. Your involvement will not affect your management plan. Participation is voluntary and consent may be revoked at any time. There are no additional risks associated with being involved in BBC collecting your de-identified clinical information.

PLEASE DO NOT SIGN UNTIL YOU HAVE SPOKEN TO YOUR CHIROPRACTOR.

I have read the above and acknowledge I am aware of and understand the potential risks. I do not expect the chiropractor to be able to anticipate or explain all the risks and complications. I wish to rely on the chiropractor to exercise her/his judgement during the course of the procedures which she/he feels, at the time, based upon the facts known, is in my best interests.

I have had the opportunity to discuss with the chiropractor and ask questions about the nature and purpose of the examination and treatment and all of my concerns. I understand that results are not guaranteed.

Please tick

□ The information provided is accurate and fully inclusive to the best of my knowledge. I understand the advice and treatment plan is made on the information that I provide. I will update my practitioner on any medical conditions or health concerns as they arise.

□ I hereby request and consent to chiropractic examination and management of my child. I understand that I can withdraw my consent at any time.

□ I hereby consent for my child's de-identified information to be used in research and presentations.

□ I consent to information being sent to third parties when I have authorised it (eg: private health insurance)

□ I understand I must provide 24 hours notice if I'm unable to attend my scheduled appointment to avoid paying a 50% cancelation fee. If I fail to provide notice that I cannot attend my appointment, I will be liable for 100% of the consultation fees. I also understand that all fees are payable on the day of consultation.

I, ________________________________ (Parent / legal guardian's name), am the legal

guardian of ________________________________ (child's name) and consent to his / her care.

SIGNATURE________________________________ DATE____________________

CHIROPRACTOR'S SIGNATURE________________________ DATE____________________

(Own behalf of any current or future doctors of chiropractor of Body and Brain Centre)

Physical	Brain	Emotional	Nutritional	Traditional
Chiropractic	Biofeedback	Counselling	Dietetics/Nutrition	Acupuncture
Myotherapy	Neuro-Rehab	Meditation	Naturopathy	Chinese Medicine
Remedial Massage	Brain Scans			