Welcome to Body & Brain Centre!

Date: ________________

Name: ____ **DOB:** ________________ **Age:** _________

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

Siblings' Names & Ages: ____

Address: ___________________________________ **Suburb:** ______________ **Postcode:** ________

Mum's Mobile: ________________ **Dad's Mobile:** ________________

Email Address: ____

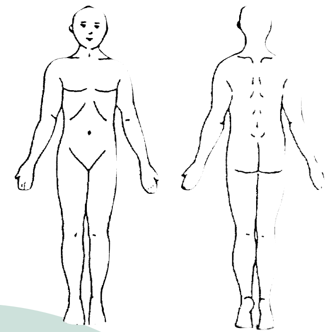
Please Tick: ❒ I would like to receive newsletters with special offers, health tips and more.

Who can we thank for referring you? ❒ Sign ❒ BodyBrainCentre Website ❒ Google ❒ Facebook ❒ GP ❒ Other Practitioner ❒ Patient **Name of Dr or Patient:** ________________________________

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

For What: ____

Please describe your present condition/s, how 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 ❒ Good Health

Details / Other: ____

____

Birth

Where was your child born? ____

How long was the labour? From time of first contraction until birth __________________________

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

Was your Child in a Hospital Crib after Delivery? ❒ Yes ❒ No

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)

Details: ____

According to your midwife / obstetrician, did your child become distressed at any time?

____

____

Infant / Toddler History

Was the Child Breastfeed? ❐ Yes ❐ No **If Yes, For How Long?** ____________________

Did Your Child Have Any Developmental Delays? ❐ Yes ❐ No **Details:** ____________________

____

Describe Your Child's Steps in Learning to Walk Eg: commando crawling —> cruising along furniture —> Frankenstein walking. Feel free to be descriptive.

____
____
____

School / Educational Background

Where does your Child Attend School? ____________________ **Grade:** ______

Has your Child Experienced any Learning Difficulties? ❐ Yes with details below ❐ No

Has your Child Experienced any Behavioural Difficulties? ❐ Yes with details below ❐ No

Details: ____________________

____

What's Your Chid's Favourite Subject(s)? ____________________
Least Liked Subject(s)? ____________________

Has your Child Been: ❐ Expelled / Suspended from school ❐ Repeated Grades ❐ Been Tutored ❐ Attended Special Classes (eg: reading recovery) **Subjects:** ____________________

Pubescent Health

What was the First Sign of Puberty (if any) and When? ____________________

When was your Child's Last Growth Sport? ______________ **How Much Growth?** ______ cm

Please Tick which Pubescent Changes Your Child Has Experienced:

- ❐ Genital growth
- ❐ Underarm & body hair
- ❐ Muscle development
- ❐ Pubic hair
- ❐ Oily skin
- ❐ Moodiness
- ❐ Facial hair
- ❐ Increased sweat production
- ❐ Change in voice

Overall Health

What is your Child's Hobbies and Interests? ____________________

____

Has Your Child Experienced Any: ❐ Falls ❐ Accidents ❐ Fractures / Dislocation ❐ Sprains ❐ Surgeries / Hospitalisations ❐ Significant Hardship / Stress **and When They Occurred**
Details: ____________________

____

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

____

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

How do you rate your child's: General wellbeing ___/10 **Why?** ____________________

Please list Your Child's Medication (including Supplements):
Current: ____________________
Significant Previous: ____________________

Has Your Child Had or Having Problems with:

Past	Current	N/A		Past	Current	N/A	
❐	❐	❐	Bowels	❐	❐	❐	Eczema / Skin Conditions
❐	❐	❐	Breastfeeding Difficulties	❐	❐	❐	Allergies / Intolerances
❐	❐	❐	Bedwetting	❐	❐	❐	Sleep (terrors, walking, etc)
❐	❐	❐	Recurrent Bladder Infections	❐	❐	❐	Sensitivity to Light, Touch, Noises
❐	❐	❐	Recurrent Throat Infections	❐	❐	❐	Growing Pains
❐	❐	❐	Recurrent Ear Infections	❐	❐	❐	Restless Legs
❐	❐	❐	Reflux	❐	❐	❐	Headaches
❐	❐	❐	Co-Ordination / Movement	❐	❐	❐	Scoliosis
❐	❐	❐	Accident Prone Child	❐	❐	❐	Colic
❐	❐	❐	Learning Difficulties	❐	❐	❐	Moodiness / Tantrums
❐	❐	❐	Attention Difficulties	❐	❐	❐	Epilepsy / Seizures
❐	❐	❐	Hyperactivity	❐	❐	❐	Tics / Twitches / Tourrettes
❐	❐	❐	Reading or Comprehension	❐	❐	❐	Asthma
❐	❐	❐	Messy Handwriting	❐	❐	❐	Sinus
❐	❐	❐	Arithmetic	❐	❐	❐	Social Difficulties
❐	❐	❐	Anxiety	❐	❐	❐	Separation Anxiety
❐	❐	❐	Chicken Pox	❐	❐	❐	Eating Disorders
❐	❐	❐	Risky Behaviour	❐	❐	❐	Confidence Issues

Is there a Family History of any Major or Recurring Illness / Diseases? Eg: heart attack, cancer, anxiety, depression, dementia, diabetes, thyroid, seizures, learning difficulties, behaviour conditions, allergies / intolerances

____

____

____

Does Anyone In the Household: ❐ Smoke ❐ Drink more than 7 alcoholic drinks per week

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. If anything causes pain, we will discontinue but note it to make an accurate diagnosis.

2. **Non-trust mobilisations of the spine, extremities (arms & legs) and / or cranium:** Gentle pressure or stretches may be used to relieve tension and promote normal movement patterns. No known adverse reactions.

3. **Low force joint mobilisations of the spine, extremities (arms & legs) and / or cranium** including gentle cranial massage, blocking / mechanical wedges, drop piece-assisted adjustments or Activator ("clicker"). No known adverse reactions.

4. **Gentle manual adjustments of the spine and / or extremities (arms & legs):** Rarely mild adverse reactions occur (0.53 - 1%) including irritability or soreness lasting less than 24 hours.

5. **Massage and soft tissue techniques:** Skin irritation, bruising / redness, minor discomfort, aching or fatigue are possible risks.

6. **Electrical stimulation:** Mostly commonly, a tingle, itch, slight sting or forceful muscle contraction is felt. Infrequently, burns from improper settings or allergic reaction to electrodes are possible.

7. **Laser:** There have been no reported adverse reactions in the literature however it is theoretically possible that laser therapy can cause permanent eye damage if protective eye wear is not worn. Infrequently, a mild ache be experienced in the following 24 - 48 hours.

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

9. **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.

10. **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 (pain killers, anti-inflammatories or other medication), 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. I also understand that 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 care.

SIGNATURE____ DATE____________________

CHIROPRACTOR'S SIGNATURE__________________________________ DATE__________________