ALIGNED CHIROPRACTIC

Given name: **Surname:**

Address:

Guardian's name: **Relationship to patient:**

Date of birth: **Email:**

Mobile phone: **Home:** **Guardian's phone:**

Occupation (if applicable):

Private health fund: **yes / no** **Which fund?:** **Your doctor:**

How did you hear about us?

☐ **Friend/Family member**_____ ☐ **Google search**

☐ **GP/Health practitioner**_____ ☐ **Yellow pages**

☐ **Local directories** ☐ **Our website** ☐ **Signage/Passing by** ☐ **Other:**_____

Present State of Health

It surprises many people when they discover Chiropractic doctors don't treat symptoms. Instead they find the underlying cause(s) of your particular issues and assist your body in the healing process. Chiropractors understand that symptoms may indicate that there is something not functioning properly in the body, or they may just be healthy warning signs from an optimally functioning body that is being overstressed.

People present to this clinic in various stages of health or health decline. If you are experiencing symptoms please describe them as clearly as you can by answering the following:

Major problem/symptom

When did the problem start? **How did it start?**

Have this problem occurred before? **Yes / No** **How often?**

Pains are: ☐ **Sharp** ☐ **Dull** ☐ **Constant** ☐ **Intermittent**

Is the pain referring to other areas? **Yes / No** **If so, where?**

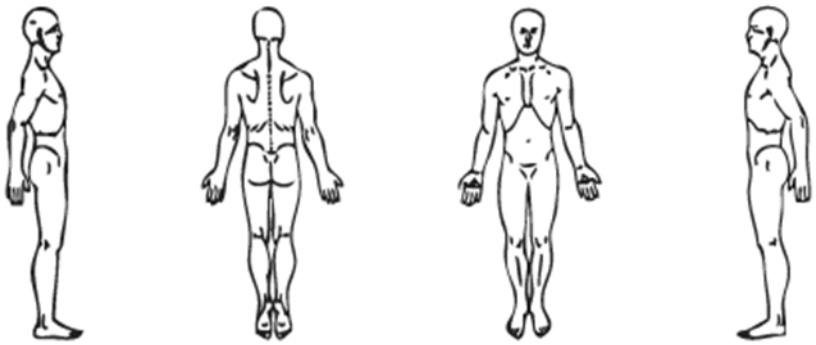
Is the condition getting worse? **Yes / No** **Is the problem disrupting normal activities?** **Yes /No**

What treatment has been administered for this condition?

What aggravates the problem?

What helps or relieves the problem?

PLEASE MARK ON THE DIAGRAM BELOW WHERE YOUR COMPLAINT AREAS ARE: -



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Patient History

During pregnancy did the child's mother:

Have an injury Yes / No **Have good nutrition** Yes / No **Exercise regularly** Yes / No

Smoke or drink alcohol Yes / No **Take medication/drugs** Yes / No

Birth process:

Was the delivery long Yes / No **Was the delivery difficult** Yes / No **Caesarean** Yes / No

Breach Yes / No **Induced** Yes / No **Forceps/vacuum extraction** Yes / No

Head bruising Yes / No **Drugs during labour** Yes / No **Hospital birth** Yes / No

As a baby:

Was child breastfed Yes / No **Was child a head banger** Yes / No

Did child ever fall on head Yes / No **Did child ever fall down stairs** Yes / No

Psychosocial-any recent events:

Death (family/friend) Yes / No **Divorce/separation** Yes / No **Depression** Yes / No

Family problems Yes / No **Sleep disturbances** Yes / No **Other:**

Has or does the child have any problems with (tick the ones that apply)**:**

Bowels	Breast feeding difficulties	Bedwetting	Bladder infections	Throat infections
Ear infections	Attention deficit disorder	Co-ordination	Learning difficulties	Growing pains
Appendicitis	Eczema	Allergies	Restless legs	Headache/migraine
Colic	Moodiness	Asthma	Epilepsy	Sinus

Has the child been treated for any other major disease or illness?:_____

_____

List any current or recently taken drugs/medications:

Drug/medication name	Dosage	Reason for use

Has the child had chiropractic care before? ☐ No ☐ Yes - if yes, when?_____

Were any spinal x-rays taken? ☐ No ☐ Yes – if yes, how long ago?_____

Which spinal areas were x-rayed? ☐ Neck ☐ Mid-back ☐ Low-back ☐ Pelvis

Sleeping position: ☐ Back ☐ Stomach ☐ Side Age of mattress:_____ No. of pillows:_____

Females only- ☐ ☐

Are you or could you be pregnant? Yes / No **Are your menses regular?** Yes / No

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Family 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. Please list any family members that have had any health problems such as migraine, stroke, heart disease, blood diseases, arthritis, spina bifida etc.

Relationship to Child	Past or Present Health Problems

Privacy policy statement:

In accordance with the new Privacy Act, all information relative to your case is held in total confidence. However, your consent is necessary to allow us to exchange information between Chiropractors within this clinic. Also when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

Patient Name: _____

Signature of parent or guardian: _____ Date: _____

Patient Information

Changes to the law now require all practitioners who manipulate the spine to warn patients of material risks. In extremely rare circumstances, some treatment of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms. (Current literature states this to be approximately 1 in 1-2 million according to D. Chapman-Smith, seminar 2002 and approximately 1 in 5.85 million neck manipulations according to Haldeman, et al, Spine vol. 24-8 1999).

Whilst this has never occurred in this practice, we are still required to warn. If any adjustments (manipulations) are required you will be tested beforehand, as has always been our practice.

Other very slight risks include strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the lower back (1 in 62,000).

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

Please note that this consent does not waiver your Common Law Rights, rather it is merely for you to acknowledge that you have been informed of the known risks.

If you have any questions related to the treatment you are about to receive or possible alternative approaches, please speak to the chiropractor.

I have discussed the above information with the Chiropractor, I agree to the office policies and give my consent to treatment of the child in my care.

Signature of parent or guardian: _____ Date: _____

Chiropractor's Signature: _____ Date: _____