Paediatric New Patient Form

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? ☐ Yes ☐ No

If no, name of guardian(s)

Names & ages of siblings | Email:

Address | Town/City | Postcode

Home Ph | Business Ph | Mobile

Health Fund

Who referred you to our clinic?
- ☐ Friend or Acquaintance (name): _____
- ☐ Family member (name): _____
- ☐ Another Health Professional (please specify) _____
- ☐ Our Signage
- ☐ Yellow Pages ○ *Online* ○ *Print* ☐ Website
- ☐ Advertising ☐ Facebook
- ☐ Location ☐ Natural Therapy Pages
- ☐ Other (please specify): _____

Major Complaint

How long has this condition existed?

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

Previous diagnosis/treatment for this condition

Other complaints

On any medication/Supplements?

List any Surgery/Accident/Falls/Illnesses

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?

GP/Paediatrician Details:

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During pregnancy did the child's mother

Have an injury	☐ Yes	☐ No
Have good nutrition	☐ Yes	☐ No
Exercise	☐ Yes	☐ No
Smoke or drink alcohol	☐ Yes	☐ No
Take any medication	☐ Yes	☐ No

As a Baby

Was child breastfed	☐ Yes	☐ No
Was child a headbanger	☐ Yes	☐ No
Did child ever fall on head	☐ Yes	☐ No
Did child ever fall down stairs	☐ Yes	☐ No

Birth Process

Was the delivery long	☐ Yes	☐ No
Was the delivery difficult	☐ Yes	☐ No
Forceps / vacuum extraction	☐ Yes	☐ No
Head bruising	☐ Yes	☐ No
Caesarean	☐ Yes	☐ No
Breach	☐ Yes	☐ No
Induced labour	☐ Yes	☐ No
Drugs during labour	☐ Yes	☐ No
Hospital Birth	☐ Yes	☐ No

List date of last

Physical Examination _____

Blood Test _____

Chest X-ray _____

Urine Test _____

Psychosocial any recent occurrence

Depression	☐ Yes	☐ No
Death (Family / Friends)	☐ Yes	☐ No
Divorce / Separation	☐ Yes	☐ No
Family Problems	☐ Yes	☐ No
Sleep Disturbances	☐ Yes	☐ No

Has or does child have problems with

Bowels	☐ Yes	☐ No
Breastfeeding difficulties	☐ Yes	☐ No
Bedwetting	☐ Yes	☐ No
Recurrent bladder infections	☐ Yes	☐ No
Recurrent throat infections	☐ Yes	☐ No
Recurrent ear infections	☐ Yes	☐ No
Reflux	☐ Yes	☐ No
Co-ordination	☐ Yes	☐ No
Learning difficulties	☐ Yes	☐ No
Attention deficit disorder	☐ Yes	☐ No
Messy handwriting	☐ Yes	☐ No
Sleep	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Restless legs	☐ Yes	☐ No
Growing pains	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Colic	☐ Yes	☐ No
Moodiness	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Sinus	☐ Yes	☐ No
Reading or comprehension	☐ Yes	☐ No

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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

Has Your Child Ever Been Evaluated By:

- ☐ Neurologist
- ☐ Paediatrician
- ☐ Psychiatrist/Psychologist
- ☐ Occupational Therapist
- ☐ Speech or language Pathologist
- ☐ Other, Please specify: _____

Consent to treatment and examination of a minor

I hereby authorise the doctors at NeuroBalance 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 NeuroBalance 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 NeuroBalance Chiropractic at the time of service.

_____

Signature of Parent (or Guardian) Today's Date