COASTLINE Chiropractic CENTRE

Helping you restore your body's balance and freedom

Child Questionnaire

Dear Parent/Carer

It is our pleasure to welcome you to our clinic. Please complete the following questionnaire. Your answers will help us to determine whether Chiropractic can help your child. Please note this is a postural and spinal examination only. If treatment is required you will be advised. Thank You

Parent or Carer's full name: _____

Name of Child: _____
First *MI* *Surname*

Gender: ☐ Male ☐ Female ☐ Prefer not to say ☐ Other Date of birth: _____

Address: _____
Street # *Street Name* *Suburb* *Pcode*

Contact details:
Home PH: _____
Mobile PH: _____
Work PH: _____
E-mail: _____

Preferred method of contact number:
☐ home
☐ mobile
☐ work

Are you a member of a private health fund?
☐ No ☐ Yes - Fund Name: _____

Other Children's Names, Ages and Dates of Birth:

_____

_____

_____

_____

Referrals

We appreciate Referrals. How did you find out about our clinic?

☐ Friend, please names: please specify:
☐ Family member
☐ Yellow Pages
☐ Other (please specify):
☐ General Practitioner (Family Doctor)
☐ Another Health Professional
☐ Our Signage
☐ Google

If known, what is the name of your referral contact? _____

OFFICIAL USE:
Name.....
File Number.....

Child Clinical Information Form

It surprises many people when they discover chiropractic doctors don't treat symptoms, instead they find the underlying cause(s) of your ache, pain or condition, and help your body to heal. 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 then please describe these as fully and informatively as you can by answering the following:

Major symptom/problem _____

When did the pain/problem start?_____ triggered by_____

Details about childhood birth and development

The birth of your child can give vital clues as to potential spinal problems. Please answer the following questions very carefully.

Was your child delivered?

Normally	Yes	No	Breech	☐ Yes	☐ No
Posterior	Yes	No	Premature	☐ Yes	☐ No
At Term	Yes	No	Caesarian	Yes	☐ No
Late	Yes	No	Forceps	Yes	☐ No
Chemically Induced	Yes	No	Suction/Vacuum	Yes	☐ No

Other_____

Birth weight _____ APGAR Scores _____ _____

How long were you (or mother) in labour? _____ Hours How long did you "push" for? _____Mins /Hours
Do you believe the birth was traumatic for your child? Yes / No

Was your child's head misshapen at birth Yes No
Were there any delivery complications? Yes No
Details_____
_____
_____
_____
_____

OFFICIAL USE:
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Details about childhood birth and development

Was your child breast fed?	Yes	No	For how long? _____	
Was your child formula fed?	Yes	No	For how long? _____ Type _____	
Did your child suffer with colic?	Mildly	Moderately	Severely	Not at all
Did your child suffer with reflux?	Mildly	Moderately	Severely	Not at all

Would you say your child was a:

Very poor sleeper Poor sleeper Average sleeper Good sleeper Very good sleeper

Medical Health

Please indicate which (if any) of the following problems your child has experienced in the past:

Headache	Allergies	Neck Pain
Back Pain	Constipation/Diarrhea	Earaches/Infections
Sinus Pain	Recurrent Tonsillitis	Bedwetting
Recurrent chest Infections	Growing Pains	Hyperactivity
Loss of appetite	Poor sleeping habits	Visual disorders
Constant fatigue	Arm/Leg pain	Poor co-ordination
Learning difficulties	Recurrent stomach aches	Digestive disorders
Scoliosis	Fever	Convulsions
Joint pains	Asthma	Travel sickness
Night Terrors	Seizures	Chronic Colds
Recurring Fevers	Hip Problems	Other_____

OFFICIAL USE:

Name.....

File Number.....

Medical Health and Medications

How long did your child crawl for? _____Months
Is your child accident-prone? Yes No Has your child had any significant falls? Yes No
Please describe any falls or accidents your child has had. _____
_____
_____
_____

Has your child ever been involved in a motor vehicle accident? ☐ Yes ☐ No
Is your child on medication? ☐ Yes ☐ No

Has your child had any diseases / illnesses? ☐ Yes ☐ No
Has your child ever been hospitalized or had surgery? ☐ Yes ☐ No If yes, please describe:

_____

Has your child ever had any broken bones or sprain injuries? ☐ Yes ☐ No If yes, please describe:
_____
_____

Vaccination history ☐ Full vaccinations ☐ Some vaccinations ☐ No vaccinations
Other:_____

Has your child ever been assessed for the presence of scoliosis? Yes No
Has your child had a learning disorder? Yes No
Has your child taken antibiotics? ☐ Yes ☐ No What for and when? _____
How many times has your child taken antibiotics?

In last six months _____ During Lifetime_____

How many doses of other Prescription Medication has your child taken? In last six months: _____ During Lifetime: _____

OFFICIAL USE:
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File Number.....

The following Documents covers essential information relating to your Informed Consent, Outcome of treatment, Waiver and Signed Consent. Please read then sign and date if you are satisfied. We welcome you to discuss with us if you have concerns.

Informed Consent

Chiropractic care is an established professional allied health service that is acknowledged to provide an effective and safer approach for many musculoskeletal conditions. As you begin Chiropractic Care, there is certain information that you must be informed.

Your therapy and treatment may include:

- Chiropractic adjustments involving manual therapy of the body including spine, pelvis and the skull
- Soft tissue therapy
- Postural and Rehabilitation Exercise.

Alternative Treatment options

There are numerous therapeutic options for Musculoskeletal conditions

These include: Massage, Physical Therapy, Acupuncture, Osteopathy and Medication.

Possible outcomes

Individual response to Chiropractic treatment will vary. There may be an improvement, no change or a worsening of symptoms. Scheduled apart of the care management are routine examinations to assess your change.

Potential Risks of Proposed Treatment

The rare risks associated with the proposed care includes (not limited to):

- muscle and joint soreness or strains,
- nausea and dizziness
- exacerbation and/or aggravation of the underlying condition.
- In very rare circumstances, some treatments of the neck may damage a blood vessel and possible Stroke or related symptoms (current statistics: between 1 in 2 million to 1 in 5.85 million -Haldeman, et al. Spine vol 24-8 1999).
- Strain/injury to a Ligament or a Disc in the Neck (current statistics: less than 1 in 139,000) and the Low back (current statistics: 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.).
- For some patients a fracture of a bone is possible, although rare, especially with bone weakening diseases.

Waiver

I hereby acknowledge my consent to the performance of the proposed chiropractic care Darren J Gray or any other chiropractor working in this centre. I understand that I can withdraw consent at any time.

I will have the opportunity to discuss the proposed care with chiropractor. I also acknowledge that I will have had the chance to ask questions about the nature, extent and purpose of the recommended chiropractic care and I have been given sufficient time to make a decision providing consent for the care to proceed.

OFFICIAL USE:
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Patient Consent Form

I consent to undergo an examination to determine the cause of the condition for which I have attended the Clinic. The consultation may entail photographic or video recordings for inclusion in my records. Further consent will be obtained for any treatment after the examination and an explanation of the findings.

Signed: _____ Dated:_____

(Parent or Guardian to sign)

I accept financial responsibility for my consultations and treatment. Fees are due at the time of consultation unless agreed in advance. Unauthorised late payments will attract fees and interest, details of which are available on request. Insurance policies are an agreement between the insurer and myself, and I am responsible for any costs I am unable to claim through a policy. I remain liable for any charges that the Clinic is unable to recover through these schemes.

Twelve hours notice of cancellation of appointments is required or the full fee for the appointment will be due. The Clinic may waive any of the above on occasions. If the Clinic does so it reserves the right to enforce the agreement at a later date.

Under 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 data between providers 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.

I understand that the practice supports the expansion of clinical knowledge and expertise. One of the ways it does this is by using clinical information for education and scientific and case studies. All identifying information is removed from any data before it is used. I consent for my data to be used in this manner. I understand I may withdraw this consent at any stage without compromising my care in any way.

Signed: _____ Dated:_____

(Parent or Guardian to sign)

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