Paediatric Case History

GMR CHIROPRACTIC
Growth - Maintenance - Repair

Dear New Client,

It is a pleasure to welcome you to our family of happy and healthy chiropractic clients. Please let us know if there is anyway we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Client Name: _____D.O.B: _____

Address: _____Suburb: _____ Post Code: _____

H. Phone: _____ Mobile Phone: _____ Weight: _____ Height: _____

Names of Parents/Guardians: _____

How did you find out about our clinic? (pls circle) Phonebook *or* Internet *or* Facebook *or* Website *or* Google

other: _____ *or* Who may we thank for referring you: _____

Have you ever received Chiropractic Care? Yes No Chiropractor's Name: _____

Email Address: _____

Purpose for contacting us: _____

Other Doctors seen for this condition: Yes No Name: _____

Check any of the following conditions your child has suffered from during the past 6 months:

O Ear Infections	O Digestive Problems	O Car Accident
O Asthma/ Allergies	O Bed Wetting	O Chronic Colds
O Colic	O Growing/Back Pains	O Recurring Fevers
O Headaches	O Seizures	O Temper Tantrums
O Scoliosis	O ADHD	O Other: _____

What are your health goals through Chiropractic?

O Relief of symptoms

O Prevention and relief of symptoms

O Overall improvement of your total health and wellbeing

Family History

Previous Chiropractor: _____ Date of Last Visit: _____

Reason: _____

Name of Pediatrician: _____ Date of Last Visit: _____

Reason: _____

Are you satisfied with the care your child received? Yes No

Antibiotics – Number of doses your child has taken:

In the last 6 months: _____ Total during lifetime: _____

Prescription Medication – Number of doses your child has taken:

In the last 6 months: _____ Total during lifetime: _____

Vaccination History: _____

_____

Prenatal History

Name of Obstetrician/Midwife: _____

Complications during pregnancy? Yes No _____

Ultrasounds during pregnancy? Yes No How many? _____

Medications during pregnancy/delivery? Yes No _____

_____

Cigarette/Alcohol use during pregnancy? Yes No

Location of Birth: Hospital: _____ Birthing Center: _____ Home: _____

Birth Intervention

Forceps: _____ Vacuum Extraction: _____ Caesarian Section: Planned Emergency

Complications during delivery? Yes No _____

Genetic Disorders or disabilities? Yes No _____

Feeding History

Breast Fed? Yes No How Long? _____

Formula Fed? Yes No How Long? _____

Introduced to solids at month: _____ Cows Milk at Month: _____

Allergies/Intolerance? Yes No _____

Developmental History

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor or chiropractor for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was you're your child able to:

Respond to sound: _____ Hold Head Up: _____ Cross Crawl: _____ Walk alone: _____

Respond to visual stimulus: _____ Sit Up: _____ Stand Alone: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., bed, changing table, down stairs, etc).

Was this the case with your child? Yes No _____

Is/has your child been involved in any high impact or contact type sports (i.e., football, martial arts?). Yes No _____

Has your child ever been involved in a car accident? Yes No _____

Has your child been seen on an emergency basis? Yes No _____

Other traumas not described above? Yes No _____

Prior Surgery? Yes No _____

Menarche? Yes No _____

Childhood Diseases

Chicken Pox:	Yes	No	Age: ____
Rubeola:	Yes	No	Age: ____
Rubella:	Yes	No	Age: ____
Mumps:	Yes	No	Age: ____
Whooping Cough	Yes	No	Age: ____
Other:	Yes	No	Age: ____

Authorization for Care of a Minor

Informed Consent

The law has changed. All practitioners who adjust the spine are now required to warn clients of material risks and seek informed consent for chiropractic care. In extremely rare circumstances, adjustments of the neck may damage blood vessels and give rise to stroke or stroke-like symptoms (less than 1 in 2,150,000). Whilst this has never occurred in this practice, we are still required to warn. If any adjustments are required, you will be tested beforehand, as has always been our practice (i.e. check for dizziness, referred pain, etc)

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

Chiropractic adjustments of the spine are internationally recognized 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, 1994 Manga Report, Ontario Ministry of Health, 1993).

If you have any questions related to the chiropractic care you are about to receive or about alternative options, please speak to the chiropractor.

I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

_____ _____

Client or Guardian's Signature Chiropractor's Signature

_____ _____

Client's Name Date

WE ARE HERE TO SERVE YOU AND TO ENCOURAGE YOU TO ASK QUESTIONS.

YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR CHILDS' RESULTS.