9 Station St, Mitcham 3132
487 Bridge Rd, Richmond 3121
T 03 9873 7373

BetterBacks
CHIROPRACTIC & NATURAL PRODUCTS

Pediatric Patient Information

Name: _____Today's Date:_____

Parent's/Guardian's Name(s):_____

Home Phone: _____ Parent's Mob: _____

Mailing Address:_____ Suburb:_____ post code:_____

Birth Date:_____ Age:_____ Sex: ❑ M ❑ F Parent's E-mail Address:_____

How did you find us?_____Previous Chiropractic Care: ❑ Yes ❑No, Approx Last Date:___

Please check reasons for pursuing chiropractic care for your child:

❑ He/she is continuing ongoing care from another chiropractor.
❑ I recently had my spine checked and see the value in getting my child checked.
❑ I'm concerned about his/her health and I'm looking for answers.
❑ He/she has a specific condition that concerns me.
Explain condition or symptom:

_____

❑ I want to improve my child's immune function.
❑ I have no idea why we're here. Please take the time to explain to me what you can offer my child(ren).

In order for us to better understand your child's current level of health, please check any of the following body signals which he/she has or has had previously:

❑ Headaches/Migraines ❑ Asthma ❑ Sleep Problems ❑ Weight Problems ❑ ADD/ADHD
❑ Postural Imbalance ❑ PDD/Autism ❑ Seizures ❑ Frequent Colds ❑ Allergy/Sinus Problems
❑ Bedwetting❑ Ear Infection ❑ Car Accident ❑ Colic ❑ Digestive Problems❑ Scoliosis
❑ Growing/Back Problems ❑Feeding Problems ❑Other Problems

Number of doses of antibiotics your child has taken:

During the past 6 months:_____
Total during his/her lifetime:_____
List reasons_____

Number of doses of other prescription medications your child has taken:

During the past 6 months:_____
Total during his/her lifetime:_____
List reasons:_____

Prenatal History:

Adopted: ❑ Yes ❑ No
Complications During Pregnancy: ❑ Yes ❑ No
List reasons:_____
Ultrasounds During Pregnancy: ❑ Yes ❑ No
Number:_____
Medications/drugs/caffeine use during pregnancy? ❑ Yes ❑ No
Please list:_____
Cigarette/Alcohol use during pregnancy? ❑ Yes ❑ No
Location of birth: ❑ Hospital ❑ Birthing Center ❑ Home

Birth Intervention:

❑ Mother Induced ❑ Mother medicated (Pitocin, etc) ❑ Cesarian Section
❑ Forceps ❑ Vacuum Extracted ❑ Baby given medication after delivery
Complications During Delivery: ❑ Yes ❑ No
List:_____
Genetic Disorders or Disabilities: ❑ Yes ❑ No
List:_____
Birth weight: _____Birth length:_____ APGAR score 1 min._____ 5 min._____

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If premature how early?_____
Breast Fed? ❑ Yes ❑ No How Long?_ _____ Formula Fed? ❑ Yes ❑ No
How Long & what formula?_____
Food or Other Allergies? ❑ Yes ❑ No List:_____
How many wet nappies a day (no.1s)?_____ dirty nappies(no. 2s)?_____

SLEEP
Hours per night_____ Naps (number & length)_____

Any sleep problems?_____

DEVELOPMENT
At what age did your child: sit alone_____ walk alone_____ say words____ toilet train (daytime)_____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ex. A bed, changing table, down stairs, etc.). Was this the case with your child?
❑ Yes ❑ No List:_____
Is/Has your child been involved in any high-impact or contact-type sports (ex. Soccer, football, gymnastics, hockey, basketball, cheerleading, martial arts, etc.)?
❑ Yes ❑ No List:_____
Has your child been seen in an emergency room?
❑ Yes ❑ No List:_____
Prior surgery?
❑ Yes ❑ No List:_____

Consent to evaluation and adjustment of a minor child

Chiropractic care is very safe and effective for many conditions. However with any form of healthcare no one can guarantee results and there potential risks and rare complications that you should be informed about. These include although not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries, strokes (or like episodes) and an exacerbation and/or aggravation of the underlying condition. Often these potential risks and complications cannot be anticipated.

The most serious potential injury is that of a stroke and its risk is estimated to be one incident in every 1 to 5.8 million adjustments. These are that rare that 24 out of 25 chiropractors practicing full time for 40 years will never see one.

Your answers to this confidential questionnaire will help ensure any risks are minimized and that appropriate care is provided. We rely on the accuracy and completeness of what you tell us.

We comply with the Privacy Act which details what information is collected, how it is used or disclosed, how each patients records are kept and made accurate. We do not share your information with other people without your prior permission. At all times your comfort and peace of mind is important so please tell us if you have any concerns.
Please remember, if at any stage you have other questions or concerns feel free to ask.

DO NOT SIGN the following until you have spoken with your Chiropractor:

I understand the above, have been given the opportunity to ask questions and have been satisfied with the answers. Having discussed and understood the Chiropractors recommendations, I grant permission for care to proceed. I understand I can withdraw this permission at any time.

I _____ being the parent or legal guardian of _____
(print name of consenting adult) (print name of minor)
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
Consenting Adult's Signature Date