Funnell Chiropractic Child (6-16) History Form

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.

Patient name:_______________________________________ Today's date: _______________

Date of birth:______________________ Age:_________ Sex: Male / Female (Please circle)

Address:____

____

Postal address if different: ____

____

Mobile: _______________________ Email address:__________________________________

Home Ph: _____________________ Parents Work Ph:_________________________________

Reason for visit to us today: ____

Name of person who referred you (e.g. Midwife, friend…)? __________________________

Previous Chiropractor: ______________________________ Date of last visit: ___________

Name of Medical Doctor _____________________________ Date of last visit: ___________

Health History:

Check any of the following conditions your child has suffered in the past or present:

☐ Ear infection / Scoliosis ☐ Seizures ☐ Chronic Colds☐ Headaches
☐ Asthma / Allergies ☐ Digestive Problems ☐ ADHD ☐ Constipation
☐ Growing/Back Pains ☐ Colic Bed Wetting ☐ Car Accident ☐ Temper Tantrums

☐ Other ____

Number of doses of antibiotics your child has taken: ___________________________________

Prior surgery: ☐ Yes ☐ No If yes, please list: ____________________________

Birth History:

` ☐ Forceps ☐ Vacuum extraction ☐ Normal Vaginal ☐ Breech
☐ Caesarian section: Emergency / Planned

Complication during delivery? ☐ No ☐ Yes Please list? ____________________________

Genetic disorders or disabilities? ☐ No ☐ Yes Please list? ____________________________

Developmental History:

According to the US national Safety Council, approximately 50% of children fall headfirst from a high place during the first year of life (i.e., from a bed, changing table, down stairs etc). Was this the case with your child?
☐ No ☐ Yes

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No of hours sleep per night: _______________ Quality of sleep: ☐ Good ☐ Fair ☐ Poor

Please include any comments regarding your child's health here

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What accidents has your child had during their life that you can remember?
(Include minor falls, hitting head, falls off bicycle, and minor car accidents. etc)

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Please indicate if your child is involved in any sporting activity.

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We are here to serve you, and encourage you to ask questions. Your participation is vital and will help determine your results.

Authorisation for care of minor

I hereby authorize this office and its Chiropractors to administer care, scan and xrays 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.

Name of Parent / Guardian:_______________________________________

Signed:____Date:______________

INFORMED CONSENT FOR CHIROPRACTIC CARE

Changes to the law now require all practitioners who manipulate the spine to warn patients of material risks. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (approx 1 in 5.85 mil. Neck manipulations. Haldeman, et al. Spine vo124-8 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 low back (1 in 62,000). [Dvorak study in Principles and Practice of Chiropractic, Haldeman. 2°d Ed.]

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.)

The procedures to be used in your case will be described after which you will be asked if you have any questions. After speaking with the chiropractor we request that you sign below as your consent to proceed is required. Please note there may be a considerable degree of variation in individual patient response.

Patient's or Guardian's signature____

Print name here ____