Catalyst Chiropractic
604 Barkly Street, Ballarat Vic 3350

CONFIDENTIAL CLIENT INFORMATION

Dear Parent,

It is our pleasure to welcome you to our Chiropractic Centre. Please complete the following questionnaire. Your answers will help us to determine whether chiropractic care can help your child. Please note this consultation is a postural and spinal examination only. No chiropractic care will be rendered. If care is required you will be advised of this and an appointment can be made for a later date.

Thank You.

Name of Child: _____ DOB: _____/_____/_____ Age: ____

Parents Names: Father _____

Mother _____

Address: _____

_____

Medicare No: _____

Do you have concession? Yes / No Number: _____

Contact Phone Numbers:

Home: _____ Mobile: _____ Work: _____

Email: _____

Other Children's Names

_____ DOB: _____/_____/_____ Age: ____

_____ DOB: _____/_____/_____ Age: ____

_____ DOB: _____/_____/_____ Age: ____

_____ DOB: _____/_____/_____ Age: ____

Whom shall we thank for referring your child to our clinic? _____

Do you have private health insurance for chiropractic? Yes / No / Unsure

If so, which fund?

_____

What concerns do you have regarding the health of your child?

_____

_____

_____

_____

BIRTH

The details of 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 in labour? _____ Hrs 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 mis-shapen at birth? Yes / No

Were there any delivery complications? Yes / No

Details

_____

_____

_____

_____

BIRTH TO SIX MONTHS

Was your child breast fed? Yes / No For how long? _____

Was your child formula fed? Yes / No For how long? _____

Did your child suffer with colic? Yes / No For how long? _____

Did your child suffer with reflux? Yes / No For how long? _____

Would you say your child was a:

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

OTHER PROBLEMS

Please indicate by circling any of the following conditions which your child has experienced in the past:

Headache	Allergies
Neck Pain	Back Pain
Constipation/Diarrhoea	Earaches/Infections
Sinus Pain	Recurrent tonsillitis
Bed wetting	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 Cold
Recurring Fevers	Hip Problems

Other

_____

MEDICAL HISTORY

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

Vaccination History? _____

Has your child had any diseases / illnesses? Yes / No

Has your child ever been hospitalised 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: _____

_____

Has your child ever been assessed for the presence of scoliosis? Yes / No

Has your child had a learning disorder? Yes / No

How many times has your child taken antibiotics? In the last six months _____

During Lifetime _____

PREVIOUS CHIROPRACTIC CARE

Has your child had previous chiropractic care? Yes / No

Reason for care _____

Date of last care _____/_____/_____ Name of Chiropractor _____

Location of Clinic _____ Were x-rays taken? Yes / No

How would you describe the care received? Excellent ____ Good ____ Fair ____ Poor ___

CONSENT TO CHIROPRACTIC CARE

Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks associated with all health care procedures, including assessment and treatment, which you should be informed about.

Please read the following carefully:

1. I acknowledge that I have discussed with my chiropractor the rare risks associated with my proposed care which include but are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries including disc encroachments/ruptures, causing nerve irritation and referred symptoms, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition. Such risks may result in outcomes such as referral, further tests, surgery, incapacity and the like.

2. I also acknowledge the following additional potential risks insofar as my proposed care is concerned have been explained to me.
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3. I have had the opportunity to discuss the proposed care with my chiropractor. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed chiropractic care and that I have been given sufficient time to make a decision giving consent for care to proceed.

4. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.

5. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.

6. I hereby acknowledge my consent to the performance of the proposed chiropractic care by Dr David Griffiths and/or any other chiropractor working in this clinic. I understand I can withdraw consent at any time.

7. *In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (**current statistics** eg between 1 in 2 million to 1 in 5.85 million- Haldeman, et al. Spine vol 24-8 1999). Other possible risks include strain/injury to a ligament or a disc in the neck (**current statistics** eg less that 1 in 139,000) and low back (**current statistics** 1 in 62,000 Dvorak study in Principles and Practice of Chiropractic, Haldeman 2nd Ed.). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible.*

……..
Patient's Signature
(Parent or Guardian to also sign if patient is under 18)

……..
Patient's Name (printed)

…….
Chiropractor's Signature

……..
Date