# Lifecare Chiropractic

## Confidential New Child Patient Form 2 – 12 Years

Child's Name:_____DOB:_____Age:_____

Sex M / F Home Phone:_____Mobile Phone:_____

Address:_____

Email:_____

Mother's Name :_____ Father's Name:_____

GP / Paediatrician:_____Date of Last Visit:_____

Who may we thank for referring you to the clinic: _____

Chief concern or check-up: _____

Has your child had chiropractic care previously? Y / N

If yes- Chiropractor's Name:_____

Date of Last Visit:_____

Reason for Care:_____

Has your child had any X-Rays taken? Y / N
If so, explain:_____

Age of mother at birth:_____ Previous Pregnancies:_____

Number of Siblings:_____

**Maternal Health:**

Please tick if you experienced any of the following during pregnancy.

- ☐ High blood pressure
- ☐ Proteinuria (blood in urine)
- ☐ Infection
- ☐ Major stressful episodes
- ☐ Gestational diabetes
- ☐ Placenta Previa
- ☐ Pre-Eclampsia Anaemia
- ☐ Drug use (alcohol, caffeine, cigarettes including passive smoking, etc.)
- ☐ Illness – Please specify: _____
- ☐ X-rays or ultrasound taken
- ☐ Medication – Please specify: _____
- ☐ Other: _____

Duration of Pregnancy:_____

Length of Labour: _____
(when contractions are < /= 10 mins apart):

**Place of Birth:**

☐ Hospital ☐ Home ☐ Birth Centre ☐ Midwife

**Delivery:**

Please tick any that apply

☐ Vaginal Delivery ☐ Planned Caesarean ☐ Emergency Caesarean

☐ Induced Labour ☐ Forceps Delivery ☐ Vacuum Extraction

☐ Injection/Epidural/Gas ☐ Membrane Artificially Ruptured

**Birth:**

Please tick any that apply

☐ Foetal Distress ☐ Meconium Staining ☐ Jaundice

☐Head Presentation ☐ Face Presentation ☐ Breech Presentation

☐ Cord Around Neck ☐ Respiratory Distress ☐ Collar Bone Injury

0 Please specify:_____

**Developmental and Neurosensory:**

| | **Frequently** | **Occasionally** | **Rarely** |
|---|---|---|---|
| Does your child avoid busy places or crowds? | ☐ | ☐ | ☐ |
| Does your child dislike tags or tight clothes? | ☐ | ☐ | ☐ |
| Does your child trip and fall constantly? | ☐ | ☐ | ☐ |
| Is your child unable to keep their hands to themselves? | ☐ | ☐ | ☐ |
| Does your child dislike strong smells? | ☐ | ☐ | ☐ |
| Does your child constantly smell everything? | ☐ | ☐ | ☐ |
| Does your child dislike loud noises (i.e. covering their ears)? | ☐ | ☐ | ☐ |
| Does your child seem to ignore you? | ☐ | ☐ | ☐ |
| Does your child have difficulty or avoid speaking? | ☐ | ☐ | ☐ |
| Does your child dislike stairs? | ☐ | ☐ | ☐ |
| Does your child dislike or avoid bright lights? | ☐ | ☐ | ☐ |
| Does your child squint or turn their head to see? | ☐ | ☐ | ☐ |
| Does your child experience motion sickness? | ☐ | ☐ | ☐ |

| | Frequently | Occasionally | Rarely |
|---|---|---|---|
| Does your child dislike or avoid movement activities? | ☐ | ☐ | ☐ |
| Does your child experience bedwetting? | ☐ | ☐ | ☐ |
| Does your child constantly lick or suck something? | ☐ | ☐ | ☐ |
| Is your child coordinated with sports or activities? | ☐ | ☐ | ☐ |

**Trauma:**

| Please tick and comment if required: | Yes | No | Comment |
|---|---|---|---|
| Has your child ever fallen on their head or bottom? | ☐ | ☐ | |
| Has your child ever fallen down stairs or from a height (i.e. change table, bed, slide)? | ☐ | ☐ | |
| Has your child ever been in a car accident? | ☐ | ☐ | |
| Has your child ever had a bone fracture or joint dislocation? | ☐ | ☐ | |
| Has your child been hospitalised since birth? | ☐ | ☐ | |
| Has your child ever sustained an injury playing organised sports? | ☐ | ☐ | |
| Does/has your child ever repeatedly banged their head against a wall or object? | ☐ | ☐ | |

**General Health:**

| Please tick and comment if required: | Yes | No | Comment |
|---|---|---|---|
| Does your child have any sleep difficulties? | ☐ | ☐ | |
| Does your child have any digestive disturbances? ☐ | ☐ | | |
| Are your child's bowel movements normal? | ☐ | ☐ | |
| Has/does your child have asthma? | ☐ | ☐ | |
| Does your child ever complain of back, neck, or aches and pains? | ☐ | ☐ | |
| Has your child had any earaches? | ☐ | ☐ | |
| Do they usually occur in the same ear? | ☐ | ☐ | |
| Has your child had antibiotics? | ☐ | ☐ | |
| Does your child ever complain of headaches? | ☐ | ☐ | |

| | Yes | No | Comment |
|---|---|---|---|
| Has your child been vaccinated? | ☐ | ☐ | |
| If yes, did your child experience any negative reactions? | ☐ | ☐ | |
| Has your child been diagnosed with any other diseases or illnesses? | ☐ | ☐ | |
| Is your child currently taking any medications or supplements? | ☐ | ☐ | |

Do you have any other concerns that you wish to discuss?

_____

_____

_____

**Informed Consent to Chiropractic Care**

Please read the following carefully and sign below to certify that the information you have provided is correct to the best of your knowledge, and that you agree to the following –

1. *I acknowledge that I have discussed with the chiropractor the rare risks associated with the proposed care of my child which include, but are not limited to, muscle or joint soreness or strains, nausea, dizziness, fractures, disc injuries, strokes or like episodes, and an exacerbation and/or aggravation of my child's underlying condition.*
2. *I have had the opportunity to discuss the proposed care of my child with the chiropractor. I acknowledge that I have had the opportunity to ask questions about the nature, extent, and purpose of the proposed care for my child and have been given sufficient time to make a decision about giving consent for the care to proceed.*
3. *I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.*
4. *I do not expect the practitioner to be able to anticipate all the potential risks and complications associated with the proposed care.*
5. *I hereby acknowledge my consent to the performance of the proposed chiropractic care of my child in this centre. I understand that I may withdraw my consent at any time.*

_____ _____ _____

Parent's Signature Chiropractor's Signature Date