New Patient Form - Child

ABOUT YOUR CHILD

Today's Date: ______/______/___________

Child's Name: ____

Gender: ☐ Boy ☐ Girl

Child's Nickname: ____

Child's Birthdate: : ______/______/__________ Age: ___________

Child's Home Phone: ______________________________________

Child's Home Address: _____________________________________

____ Post Code_______

School or Day Care currently attended:

____

Name of GP: ____

Name of GP Clinic : _______________________________________

FAMILY INFORMATION

Mother's Name: ____

Home Phone: ____

Work Phone: ____

Mobile: ____

Father's Name: ____

Home Phone: ____

Work Phone: ____

Mobile: ____

Who is Responsible for making Appointments?

☐ Mother ☐ Father ☐ Other (specify below)

____

Email : ____

How did you find out about us?: (please circle): Patient referred Signage Newspaper Web Midwife GP Other (Please specify) ________________

If a patient referred you - who should we thank for recommending you to us: ____

YOUR CHILDS HEALTH HISTORY

Please explain why you have come to see us today: ____

____

____

____

When did you first notice the problem: ____

Why do you think the problem started: ____

Does anything help relieve it: ____

Does anything make it worse: ____

Has it been getting better, worse or staying the same: ____

Has the child had this problem before: ____

Is it worse any time of the day or night: ____

Have you seen anyone else for this problem: ☐ Yes ☐ No

If 'Yes', please explain who you consulted and when: ____

____

____

Other Health Problems: ____

Medication currently being taken, for: ____

Family History of inherent illnesses: ____

____

____

Doctors Comments

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Has your child ever been treated on an Emergency Basis: ☐ Yes ☐ No If 'Yes', please describe: ____________________ Car Accidents or Other Traumas Not Described Above: ____________________ List previous Surgeries/Treatments with Dates: ____________________ ____________________ ____________________ Is / Has Your Child Been Involved in any High Impact or Contact Type Sports (i.e. Soccer, Rugby, Netball, Gymnastics, Martial Arts, etc.)? ☐ Yes ☐ No If 'Yes', please describe: ____________________ ____________________ Vaccination History: ____________________ ____________________ Tick any of the following Conditions your child has suffered from during the past 6 months: ☐ Ear Infections ☐ Chronic Colds/Flu ☐ Headaches ☐ Recurring Fevers ☐ Asthma / Allergies ☐ Growing / Back Pains ☐ Digestive Problems ☐ Constipation ☐ Bed Wetting ☐ Temper / Tantrums ☐ Colic ☐ Accidents ☐ Scoliosis ☐ ADD / ADHD ☐ Seizures ☐ Other: ___________ Please Tick if your child has suffered from any of the following Diseases: ☐ Chicken Pox ☐ Mumps ☐ Rubella (German Measles) ☐ Measles ☐ Fifth Disease ☐ Whooping Cough ☐ Tonsillitis ☐ Other: ___________	

PRENATAL HISTORY

	Doctors Comments
Obstetrician/Midwife Name and Location: ____________________	
Location of Birth: ☐ Hospital ☐ Birthing Centre ☐ Home	
Type of Birth: ☐ Normal Vaginal ☐ Breech ☐ Caesarean	*Planned or Emergency Caesarean*
Birth Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ Other ___________	
Problems during pregnancy: ____________________ Problems during labour/birth: ____________________ Problems after the birth with the baby: ____________________ Congenital Anomalies / Defects: ____________________ Healthy birth weight and size: ____________________	
Infant Feeding: ☐ Breast Feed ☐ Bottle ☐ Formula Did your baby feed well: ____________________	
Sleeping Habits: ☐ Good ☐ Fair ☐ Poor	
Approximately 50% of children fall head first from a high place during their first year of life (i.e. roll off the bed, fall off the changing table, fall down stairs, accidently dropped, etc). Was this the case with your child?: ☐ Yes ☐ No If 'Yes', please describe: ____________________ ____________________	

Dr. Marcus McAllister (Chiropractor)

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Treatment Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legal responsible) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the physician of chiropractic named here, Dr. Marcus McAllister, and/or other licensed physicians of chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Marcus McAllister and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disk injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all the risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents and by signing below. I the undersigned voluntarily consent to treatment provided by the Chiropractic physician as is necessary in his/her professional judgment. I acknowledge and understand that no guarantees regarding a cure or improvement in my condition have been made to me. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

Payment Terms

By signing below I understand and am informed that this clinic functions on a 'Payment is required at the time of Service' basis and I am financially obligated for any fees, including all amounts left outstanding. This does include and is not limited to ACC and Insurance Claims that have been rejected, exceeded treatment limit and/or exceeded the 12 month claim period. Dr Mac Chiropractic Limited reserves the right to charge overdue fees, interest and collection costs on all accounts not paid by their due date.

To be completed by the patient's representative,

____

Print Name of Patient

____

Print Name of Representative

____

Signature of Representative