

## WELCOME TO OUR PRACTICE

CHILD'S SURNAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_ POST CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ MOBILE \_\_\_\_\_ WORK \_\_\_\_\_

EMAIL \_\_\_\_\_ PRIVATE HEALTH: \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ FATHER'S NAME \_\_\_\_\_

ARE BOTH PARENTS AWARE THAT THE CHILD IS RECEIVING CARE AT THIS PRACTICE? \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR CLINIC: SIGN / YELLOW PAGES / WEBSITE / OTHER: \_\_\_\_\_

### CURRENT HEALTH CONDITION

What is your child's major problem? \_\_\_\_\_

When did this episode begin? \_\_\_\_\_

What caused this problem? \_\_\_\_\_

Is it getting better, staying the same, or getting worse? \_\_\_\_\_

What treatment has your child received for this complaint? \_\_\_\_\_

How effective was the treatment? \_\_\_\_\_

If 0 = no emotional stress whatsoever, and 10 = the most stress you have ever had; what is your family's current stress level \_\_\_\_/10?

### PRENATAL HISTORY

How old were you when your baby was born? \_\_\_\_\_

Did you have any of the following during pregnancy: Maternal infections / Bleeding / Illness / Hypertension / Protein in urine / Stress / X-rays / Other: \_\_\_\_\_

Cigarette smoke exposure during pregnancy: 2<sup>nd</sup> hand / Active / How much \_\_\_\_\_

Alcohol intake during pregnancy: Yes / No / How much \_\_\_\_\_

illicit drugs during pregnancy : Yes / No / What kind and how much \_\_\_\_\_

### PERINATAL HISTORY

Length of pregnancy:  Full term  Early-week \_\_\_\_\_  Late-week \_\_\_\_\_

Birth measurements: Weight: \_\_\_\_\_ Length: \_\_\_\_\_ Head Circumference: \_\_\_\_\_

Type of delivery:  Vaginal  Cesarean emerg.  Cesarean elective

Assistance required:  Forceps  Vontouse  Episiotomy

Was any postnatal care required: Oxygen / Suction / 'Under lights' (if jaundiced) / ICU

Antibiotics / Humidicrib / Other: \_\_\_\_\_

### INFANCY HISTORY

Is your baby: Breast fed / Bottle fed / on solids / Formula fed, brand: \_\_\_\_\_

During feeding does or did your baby: Gag / Cough / Choke / Dribble \_\_\_\_\_

Does baby dislike: Being bathed / Nappy changes / Being dressed / The car seat

### SYSTEMS REVIEW - Please circle and conditions that are or have been a problem

Rashes / Marks / Spots / Hairy patches / Birth marks / Bruises / Eczema / Discharge from eyes, ears, or nose / Tonsillitis / Ear infections / Wheezing / Difficulty breathing / Asthma / Colds / Coughs / Cyanosis (blue skin) / Irregular heart beat / Constipation / Watery stools / Bloating / Colic / Difficulty getting wind up / Blood in stools / Frothy Stools / Reflux

Bed Wetting / Smelly urine / ADD / ADHD / Allergies / Headaches / Emotional disorders / Night terrors / Tantrums / Fatigue / Growing pains / Learning disorders / Seizures /

Other: \_\_\_\_\_

Patient name: \_\_\_\_\_ Guardian name: \_\_\_\_\_ Date: \_\_\_\_\_

**FINANCIAL policy:** I understand Quest Chiropractic does not hold accounts. I am personally responsible for the full payment of all fees incurred. Guardian Signature: \_\_\_\_\_

**CHILD protection code of conduct policy:** I am aware and consent for my child/youth may be in a treatment room with the Doctor of Chiropractic, without a third party present. Guardian Signature: \_\_\_\_\_

**CONSENT for examination: Please Read Carefully**

In order for my Chiropractor to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do request and consent to the performance of such an evaluation by the chiropractor named below, or any party authorized to do so by that person. I have had the opportunity to discuss with the Doctor of Chiropractic or with any party authorized to do so, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. I understand that I may ask the doctor to stop the examination at any time. I also understand that the Chiropractor continues to be obligated for best practices delivered in my interests.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

**INFORMED CONSENT for chiropractic care: Please Read Carefully**

It has been determined that my case is suitable for chiropractic care.

After my report of findings, I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of Chiropractic adjustments and other procedures. I understand that there are, however, some risks associated with Chiropractic care, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit.

I understand that in rare cases there have been incidents of injury to the vertebral artery during the course of care to the cervical spine by medical doctors, physiotherapist, osteopaths, and chiropractors. However, the proposed mechanism of this injury is reproduced by a wide variety of trivial neck movements such as coughing, sneezing, turning your head to look out the back of a car, or having a shampoo at a hair salon. This injury is of concern because it may lead to stroke. The risk of stroke after a cervical adjustment is estimated to be approximately **1 in 1 million**. To put this in perspective, studies that have assessed the risk from interventions a non-chiropractor commonly uses for the same complaints have found the following:

- Risk of paralysis or stroke from surgeries or neck pain **15,600 per 1 million**
- Risk of death from surgery for neck pain **6,900 per 1 million**
- Risk of serious gastrointestinal event from a non-steroidal anti-inflammatory drug (e.g. Aspirin, ibuprofen) **1,000 per million**
- Risk of stroke following a chiropractic adjustment **1 per 1 million up to 1 per 5 million**

To put this further into perspective, these studies estimate the risk of death before the age of 35 due to smoking cigarettes is **1,677 per 1 million**, and annual risk for being injured in a car accident is **13,333 per 1 million**.

Another complication that may arise following a spinal adjustment is a rib fracture, muscle strain, or ligament sprain. These complications are extremely remote and the Doctor of Chiropractic is uniquely trained to assess your spine and adjust in ways that significantly diminish your risk.

I have read and understood the remote risks inherent in undergoing chiropractic care, and do not expect the Chiropractor to be able to anticipate and explain all of the risks that could possibly occur. I wish to rely on the Chiropractor to exercise judgment during the course of chiropractic care on that basis.

I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic for my present condition, and for any future conditions for which I may seek care. I realize that I may still ask questions to the Doctor at any time after I sign this consent. I understand that my consent can be withdrawn at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in my interests.

Guardian Name: \_\_\_\_\_ Guardian Signature: \_\_\_\_\_

Witness: \_\_\_\_\_ Discussed  Date: \_\_\_\_\_

Doctors of Chiropractic: Dr Jennifer Thomson, Dr Alicia Hill  
Quest Chiropractic 1/15 Roopena Street, Ingle Farm, SA, 5098