

WELCOME TO OUR PRACTICE

CHILD'S SURNAME _____ FIRST NAME _____ DOB _____

ADDRESS _____ SUBURB _____ STATE _____ 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: _____

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 have you received for this complaint? _____

How effective was the treatment? _____

Has this occurred before? _____

When? _____ **How often does it flare up?** _____

What caused this problem in the past? _____

What treatment did you receive for this complaint? _____

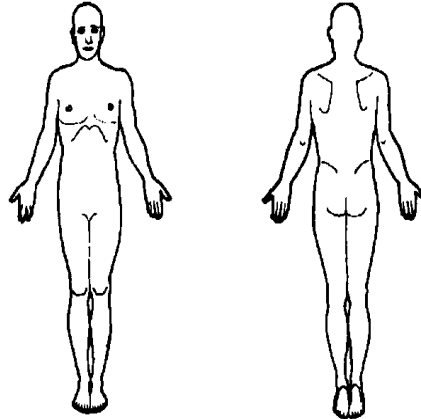
How effective was the treatment? _____

Is this a motor vehicle accident compensation claim? _____ **Claim No.** _____

Visual Analogue Scale for Pain

No Pain at all 0 _____ 10 worst possible pain.
(Place a mark on the line at the point which best represents your child's current level of pain)

Indicate the location of your pain by shading in the appropriate area



At present, or recently, has your child experienced episodes of:

Pain waking you at night Yes / No

Uncontrollable bowel or bladder function Yes / No

Pins and needles / numbness on your face or body Yes / No

Being knocked unconscious (recently) Yes / No

Has your child ever been diagnosed as having:

Cancer Yes / No

Diabetes..... Yes / No

Other serious illness / hospitalization Yes / No

SYSTEMS REVIEW

Circle any conditions that are *presently* a problem.

Underline any that were a problem in the past.

Skin: Rashes / Hairy patches / Birth marks / Eczema

Respiratory: Colds / Coughs / Difficulty breathing / Asthma

Genitourinary: Painful urination / Blood in urine / Kidney infection / Bed wetting

Neurological: Convulsions / Headache / Seizures

Cardiovascular: Palpitations / Cyanosis (blue skin) / Irregular heart beat

Gastrointestinal: Constipation / Bloating / Poor appetite / Heartburn / Nausea / Vomiting / Blood in stool

EENT: Visual dysfunction / Discharge from eyes, ears, or nose / Tonsillitis / Ear infections / Nosebleeds / Ringing in ears / Sinus infection / Enlarged glands

Other: ADD / ADHD / Allergies / Emotional disorders / Night terrors / Tantrums / Growing pains / Fatigue / Learning disorders

Additional Information: _____

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