Confidential Patient Information (Children)

Child's Name: …… Surname: ……..……Date of Birth: ……

Address: …… Suburb:…… P/Code: ……

Tel: (H). ……. (W). …… (M) ……

Email: ……

Mother's Name: …… Father's Name: ……

Please list any other children:

Name:……Age:……

Name:……Age:……

How did you find out about us (who referred you)? ……

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1) Reasons for attending this clinic

Wellness ☐ Specific problem ☐ (explain below)

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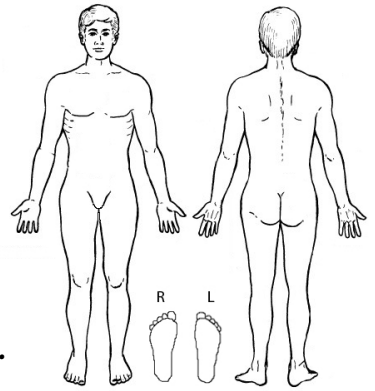

If relevant, also indicate the location of symptoms on the adjacent diagram.

Tick any of the following problems your child has experienced during the past six months:

☐ Ear Infections	☐ Scoliosis	☐ Chronic Colds	☐ Headaches
☐ Asthma/Allergies	☐ Digestive Problems	☐ Recurring Fevers	☐ Growing/Back Pain
☐ Colic	☐ Bed Wetting	☐ Posture Problems	☐ Car Accident

☐ Other……

Has your child had any significant falls or accidents? YES NO

If YES, please list: ……

……

……

Please list any past illnesses/hospitalisations: ……

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……

Please list current and past medication: ……

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Type of Birth:

☐ Normal Vaginal ☐ Forceps ☐ Breech ☐ Vacuum Extraction

☐ Caesarean Birth ☐ Home Births ☐ Birthing Centre ☐ Hospital

No of hours child sleeps per night: ……

Quality of sleep: GOOD FAIR POOR

Has your child any vaccinations? YES NO

If so, which ones? ……..

Has he/she had any reactions to these? YES NO

When was his/her last vaccination? ……

Has your child had chiropractic care before? YES NO

When? ……

Previous Chiropractor: ……...

Risks of Care & Consent for Care:

1) Chiropractic and other techniques used at this clinic are well recognized as being extremely safe health care interventions for people of all ages. However, as with all health care disciplines there is a **risk of complications.** This may include soreness; muscle, bone or joint injury; worsening of symptoms; vision, hearing or balance problems; stroke (estimated at less than 1 per million); or side-effects caused by the use of nutritional or herbal products that may be recommended. **If I have any concerns I will discuss them prior to treatment** or during the course of a treatment program if any new concerns arise.

2) I understand that the abovementioned risks of treatment exist. However, **I do not expect the practitioner to be able to anticipate all potential risks and complications** associated with the proposed care.

3) I hereby acknowledge my consent for my child to undergo assessments and treatment at this clinic and understand that I may withdraw my consent at anytime.

By signing below, I acknowledge that I have carefully read all of the above information and that I understand and agree to each point that is made.

Parent's signature …… **Date**: ……

Please print name/s here: ……

When completed, please return to **McKenzie Chiropractic** prior to your consultation:

McKenzie Chiropractic
Suite 8, 1st Floor Lygon Court,
380 Lygon St Carlton VIC 3053

P (03) 9347 3838 F (03) 9347 3292
www.mckenziechiropractic.com.au

***** Please bring any previous reports, scans or test results that may be relevant for your child's assessment.**