Child/Paediatric Patient Registration / Information Update Form

NB: This for is for any patient under the age of 16 years old

Date: / /

Title: Mr. / Ms. / Miss / Master / Other: ..... Surname: .....

Given Name: ..... Preferred Name: ..... DOB: / /

Gender: M F TG Occupation: ..... Student Year Level: .....

Address: .....

..... Postcode: .....

Phone: (Home): ..... (Mobile): ..... (Work): .....

Email: .....

Emergency Contact (Name & Phone): .....

Relationship to patient: .....

Name of GP (Medical Doctor): ..... Phone: .....

Address of GP: .....

How did you find out about us: Family / Friend / Advertising / Internet / Clinic Sign / Other: .....

Have you consulted another chiropractor before? Yes / No

- If yes, name: ..... Date of last visit (approx): .....

Do you have private health insurance with Extra's cover? Yes / No Company: .....

Do you have Health Care / Pension / Student Card? Yes / No

Card No.: ..... Exp: .....

Is this a **Medicare/EPC, TAC** or **WorkCover** claim? Yes / No Claim #: .....

Please note that Medicare, TAC and WorkCover clients must pay at the time of consultation, and be reimbursed by their respective third party payor – we are unable to bill third party payors directly.

I agree that I am ultimately responsible for the cost of my care (parent of guardian to sign):

..... Date: / / Relationship to patient: .....

Medical History:

Please list **all** surgeries, hospitalizations, traumas, disabilities and serious / chronic illnesses:

Year: …… Condition: ……

Year: …… Condition: ……

Year: …… Condition: ……

Have you experienced any of the following in the past month or since the onset of your main presenting health problem?			**Have you ever been diagnosed with any of the following health problems?**		
	YES	**NO**		**YES**	**NO**
Nausea or vomiting			High cholesterol or triglycerides		
Fever or rashes			High blood pressure		
Fatigue not resolved by sleep			Stroke, TIA or aneurysms		
Unexplained weight loss or gain			Anaemia / Low iron levels		
Dizziness, vertigo or light-headedness			Thyroid problems		
Difficulty breathing			Cancer		
Chest pain or discomfort			Diabetes or abnormal blood sugar levels		
Fainting or loss of consciousness			Allergies or immune related conditions		
Decreased urinary or bowel control			Other vascular or systemic conditions		
Pain or blood loss during urination or bowel movements			Bone or joint diseases (e.g. osteoporosis, arthritis etc.)		

Are you currently seeing a GP or specialist? Yes / No

- If yes, name/s: …… Date of last visit (approx): ……

Current medications:

……

……

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Have any of your siblings, parents or grandparents suffered from (if yes, who and what condition):

Blood disorders:	Blood disorders:
Diabetes:	Stroke:
Autoimmune diseases:	Epilepsy:
Genetic disorders:	Cancer:
Nervous system disease:	Muscle, bone or joint conditions:

Females over 12 years old:

Are you taking an oral contraceptive pill? Yes / No

Could you be pregnant? Yes / No Due Date: / / Weeks pregnant: ……..

Complete the following questions if the consultation is for a child younger than 3 years of age:

What was the duration of the pregnancy? …… / months *or* …… / weeks

Were there any complications during your pregnancy? Yes / No

- Please list: ……

Delivery type: Vaginal / Caesarean Labour duration: …… / hours

Was there any assistance required during the labour? Yes / No If yes: Suction / Forceps

Did your child spend any time in special care or NICU? Yes / No

- **If yes, please describe:** ……

APGAR scores: ……

What is your child's immunization status? ……

Did your child pass their newborn hearing test? Yes / No

- **If no, please describe:**……

Do you have concerns about your child's: Head shape Yes / No Hips Yes / No

Everyone, please complete the following context of care information:

What are your health and lifestyle goals? Why did you come to this clinic?

……

……

Please read the following information carefully before signing.

Policies on Fees, Guarantees, Disclosed Information & Research:

1) I understand that appointments not attended or cancelled with less than 24 hours notice may incur a charge and that payment is required at the time of consultation. I will also discuss any consultation fees with a health practitioner or staff member at this clinic prior to the service being provided.

2) I understand that **positive results of any treatment** that I receive at Gisborne Chiropractic Clinic **is not guaranteed**.

3) I have disclosed any past or current illness, surgery, previous trauma, medications, drug use and any known health risks in the forms and questionnaires provided, and **agree to provide any related new information** during the period of care at this clinic or by practitioners who have assessed or treated me at this clinic.

4) Information gained from the initial assessment and follow up sessions **may be used for internal research purposes** or **publishable research** to help establish improved assessment and treatment protocols and promote a greater understanding of this field of healthcare in the scientific community. No personal details (name, contact details etc.) will be disclosed in any published material.

Risks of Care & Consent for Care:

5) 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.

6) 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.

I hereby acknowledge my consent to undergo assessments and treatment at this clinic and understand that I may withdraw my consent at anytime. **I consent to a physical examination that may involve partial undressing and having the practitioner palpate(touch) me.**

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 or Guardian Signature: …….. **Date**: ……..

Please print name/s here: ……

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

71 Hamilton Street, Gisborne VIC 3437 **T**: 03 5428 2669 **F**: 03 5428 1500 **E**. info@gisbornechiropractic.com.au

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

***** For those under 4, please bring in your Maternal and Child Health record/book *****