Bright Kids

PRIVATE & CONFIDENTIAL

First Name:_____ Surname:_____

Address:_____ Postcode:_____

Telephone (M):_____ (H):_____ (W):_____

Email:_____ Date of Birth:_____ / _____ / _____

Name of Private Health fund:_____ Name of Family Doctor:_____

Please tick (✓) how you heard about us: ❑Website ❑Sign ❑ Referral (who?):_____

Please tick (✓) any of the following treatments that you have had before:

❑ Speech Therapy	❑ Acupuncture / Chinese Med	❑ Chiropractic	❑ Counselling
❑ Kinesiology	❑ Massage Therapy	❑ Naturopathy	❑ Behavioural Optometry
❑ Physiotherapy	❑ Podiatry	❑ Osteopathy	❑ Occupational Therapy

PATIENT MEDICAL HISTORY: Please tick (✓) all appropriate boxes:

❑ Abdominal or digestive problems	❑ Excessive dribbling	❑ Poor memory
❑ Allergies	❑ Fatigue	❑ Seizures
❑ Anxiety	❑ Headaches or migraine	❑ Sinus condition
❑ Arthritis	❑ Hearing problems	❑ Skin problems
❑ Asthma or lung conditions	❑ Heart/circulatory problems	❑ Sleep issues
❑ Attention difficulties	❑ Hernias	❑ Social problems
❑ Bed-wetting	❑ Hyperactivity	❑ Speech difficulties
❑ Behavioural problems	❑ Infectious disease	❑ Torticollis / wry neck
❑ Cancer/tumours	❑ Joint problems	❑ Urinary problems
❑ Colds and flu	❑ Learning difficulties	❑ Vision problems
❑ Concentration problems	❑ Motion sickness	❑ Uncoordination / uneven walking style
❑ Depression	❑ Muscle or bone injuries	❑ Other:
❑ Diabetes	❑ Muscle or joint pain	
❑ Ear ache / Ear infection	❑ Night terrors / nightmares	_____

What concerns do you have regarding your child's health?_____

Is there anything you would like your Chiropractor to know?_____

At what age did your child crawl?_____ At what age did your child walk?_____

Has your child been to hospital for any reason?_____ Any previous surgery?_____

Has you child had any major falls or accidents?_____ Any previous fractures?_____

How many courses of antibiotics has your child had?_____

Describe your child's eating habits:_____

Has your child ever suffered a reaction to vaccinations:_____

Past and **current** medications: (Including aspirin, ibuprofen, herbs, supplements etc):

_____

_____

INFORMED CONSENT AND WAIVERS: Please tick (✓) if you consent and agree to the following:

❑ I understand that True Health does not hold accounts and that I am liable for all fees incurred at time of treatment
❑ I understand that 24hrs notice must be given when cancelling a booking or a cancellation fee may be charged
❑ I consent to True Health practitioners touching my body in order to conduct their job in a professional manner
❑ I consent to allowing True Health to record my image or voice for use in photographic, audio or video footage for use in promotional / educational purposes. I understand that I am able to revoke this permission at any time. I also understand that a full waiver may be presented for my review at any time.

Name of parent or guardian:_____

Signature of patient or guardian:_____ Date:_____

CHIROPRACTIC CONSENT FORM

Changes to the law now require all practitioners who manipulate the spine to warn patients of material risks. In extremely rare circumstances, some treatments of the neck may damage blood vessels and give rise to a stroke or stroke-like symptoms (approx. 1 in 5.85 million neck manipulations).

- *Haldeman et al. Spine vol. 24-8 1999.*

Whilst this has never occurred in this clinic, we are still required to warn you of this risk. If any adjustments (manipulations) are required you will be tested beforehand, as has always been our practice.

Other very slight risks include strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000).

- *Dvorak study in Principles and Practice of Chiropractic; Haldeman 2nd Edition*

Chiropractic adjustments (manipulations) of the spine are internationally recognized as being **far safer** in dealing with neck and low back pain than medication and many other alternatives.

- *A Risk Assessment of Cervical Manipulation, JMPT, 1995.*
- *Manga Report, Ontario Ministry of Health, 1993.*

If you have any questions relating to the treatment you are about to receive, please speak to your True Health Chiropractor.

❑ I have read and understood the above information, and I give my consent to treatment.

Please print your name: _____

Signature: _____

Chiropractor's signature: _____ Date: _____