TRUE HEALTH

PRIVATE & CONFIDENTIAL

PAEDIATRIC FORM

PATIENT DETAILS

First name:		Surname:	
Address:			
Suburb:		Postcode:	
Phone (H):		Phone (W):	
Mobile:		Date of birth:	
Email:			

GUARDIAN DETAILS

Guardian 1 Name:

Guardian 2 Name:

Please tick how you heard about us:

☐ Website ☐ Yellow Pages ☐ Google ☐ Street signage

☐ Referral – who:

MEDICAL DETAILS

Name of private health fund (if applicable):

Name of family doctor:

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

☐ Speech Therapy ☐ Acupuncture/ Chinese Med ☐ Chiropractic ☐ Counselling

☐ Kinesiology ☐ Behavioural Optometry ☐ Naturopathy ☐ Massage Therapy

☐ Physiotherapy ☐ Occupational Therapy ☐ Osteopathy ☐ Podiatry

FORM CONTINUED OVERLEAF >

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PATIENT MEDICAL HISTORY

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

Other:

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?

FORM CONTINUED OVERLEAF >

PATIENT MEDICAL HISTORY (continued)

Describe your child's eating habits:	
Has your child ever suffered a reaction to vaccination?:	
Has your child been to hospital for any reason?:	
Past and **current** medications:: (Including aspirin, ibuprofen, herbs, vitamins 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 24 hours notice must be given when cancelling a booking or a cancellation fee may be charged.
- ☐ I consent to True Health practitioners touching my child's body in order to conduct their job in a professional manner.
- ☐ I consent to allowing True Health to record my child's 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 (please print):	
Signature of patient or guardian:	
Date:	