**Welcome to Connective Chiropractic, Dr Bill Logan and Dr Brandon Doyle.**

**Please take the time to complete all three of our initial consultation information forms.**

**CHILD HEALTH HISTORY (Age 3 - 16 years)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Child’s first name | | Surname | | | | | | | D.O.B. |
| Primary Carer (Mum/Dad/Grandparent/Carer) | | | | | | | | | |
| Address | | Suburb | | | | | | | Postcode |
| Home/Work Phone | | | Mobile | | | | | | |
| Email | | | | | (Required for statements/communications) | | | | |
| Secondary Carer (Mum/Dad/Grandparent/Carer) | | | | | | | | | |
| Address | | Suburb | | | | | | | Postcode |
| Home/Work Phone | | | Mobile | | | | | | |
| Email | | | | | (Required for statements/communications) | | | | |
| Do you have a Private Health Fund with Chiropractic Cover? | | | | ☐Yes ☐No | | | If Yes, Name | | |
| Who may we thank for referring you to our office? | | | | | | | | | |
| Child’s GP | | | Address | | | | | | |
| Has your child been to a chiropractor before? | | | ☐Yes ☐No | | | Were x-rays taken? ☐Yes ☐No | | | |
| Names and ages of siblings | | | | | | | | | |
| (cont/d) | | | | | | | | | |
| List any prescribed medications/drugs your child is currently taking | | | | | | | | | |
| Are you consulting our office for a | | ☐Spinal check | | | | ☐Specific health/spine concern? | | | |
| **Please describe your main area(s) of concern below:** | | | | | | | | | |
| 1. | | | | | | Age it started? | | | |
| 2. | | | | | | Age it started? | | | |
| **Does your child have or experience any of the following conditions?** | | | | | | | | | |
| ☐Heart condition | ☐Poor Digestion | | | | | | | ☐Hyperactivity | |
| ☐Skin problems | ☐Headaches | | | | | | | ☐Meningitis | |
| ☐Difficulty breathing/Asthma | ☐Sleeping problems | | | | | | | ☐Bed wetting | |
| ☐Learning Difficulties | ☐Irregular bowel movement | | | | | | | ☐Milk/lactose intolerance | |
| ☐Low back pain | ☐Fatigue | | | | | | | ☐Blood noses | |
| ☐Neck pain | ☐Irritability | | | | | | | ☐Allergies | |
| ☐Ear/throat infections | ☐Sinus problems | | | | | | | ☐Growing pains | |

**­­­­­­­­­­­­­­­Primary Carer Signature ­­­­­­­­­­­­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY**

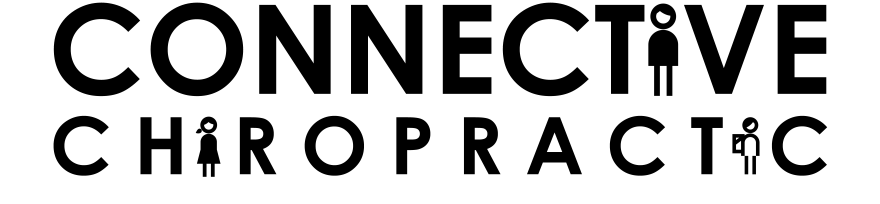
|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Were there any pre-natal complications? | | | | | | | |
| Was the child born full term? | | | | ☐Yes ☐ No If no, number of weeks premature | | | |
| How long was the labour? | | How was the infant delivered? ☐Vaginal ☐C-Section ☐Forceps ☐ Ventouse | | | | | |
| Breastfed? ☐Yes ☐ No | If yes, for how long? months | | | | | If no, name of formula | |
| Has your child been vaccinated? ☐Yes ☐No | | | | | If yes, please list: | | |
| 1. | | | Age | | 3. | | Age |
| 2. | | | Age | | 4. | | Age |
| Has your child ever been hospitalised (other than birth) or had surgery? ☐ Yes ☐ No | | | | | | | |
| Is your child on medication? ☐Yes ☐No | | | | | | | |
| Has your child ever had any broken bones or sprain injuries? ☐Yes ☐No | | | | | | | |
| Is your child accident prone? ☐Yes ☐No | | | | | | | |
| Has the child had any falls down steps? ☐Yes ☐No | | | | | | | |
| Has your child ever fallen from heights over 2 feet? ☐Yes ☐No | | | | | | | |
| Has your child ever been involved in a motor vehicle accident? ☐Yes ☐No | | | | | | | |
| Has your child a learning disorder? ☐Yes ☐No | | | | | | | |
| Do you think your child has poor posture? ☐Yes ☐No | | | | | | | |
| Is your child nervous, or has anyone suggested this? ☐Yes ☐No | | | | | | | |
| Please list any known family history that may be relevant | | | | | | | |
| (cont/d) | | | | | | | |
| Who is responsible for payment of the account? | | | | | | | |

**“Everything I have stated above is to the best of my knowledge accurate and true”**

**Child’s Name**

**Primary Carer Name**

**Primary Carer Signature** . **Date**

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**INFORMED CONSENT FOR CHIROPRACTIC CARE**

**DR WILLIAM LOGAN**

**When performed by a qualified Chiropractor, spinal manipulation is an effective and safe method of treatment for many conditions. There are however risks associated with any treatment, and Dr Logan is required to inform you of these, even though there has never been a case in this clinic (other than post treatment muscle and joint soreness). Please read the following carefully and write down any questions you may have.**

**Scope of care:** Chiropractic care is focused on finding and correcting spinal problems that alter the normal spinal shape and movement. Spinal problems may affect the healthy function of the nerves and spinal cord and can be detrimental to health. Chiropractors correct spinal problems using forces applied generally by hand or special drop piece tables. These forces made are called adjustments. Chiropractors may use various exercises, traction devices, shoe lifts or specifically prescribed orthotic devises to help the spinal corrections.

Chiropractic examinations require palpation of the spine & the pelvic region. It may also require palpation of the sternum and cranial structures including intra oral. There will be a chaperone present during examination & treatment. Private consultation and examination can be requested. Private treatment is available on special request at Rostrevor or at an alternative practice location at Tusmore.

Treatment duration will be assessed and recommended at the initial consultations, and revisited each visit as needed, with further progressive reviews done every 12 visits.

**Medication**: It is common for patients to report changes in medical health conditions. However, changes in medications or management of medical conditions need to be done by your general practitioner or specialist. Chiropractors cannot advise you as to your medical needs.

**Risks of NOT undergoing care:** Spinal problems may get worse if untreated and may lead to progressive damage of the spinal discs, the spinal nerves, the spinal cord and affect general health.

**Risks to patients:** All types of care and examinations have associated risks and it is important that a patient accepts these before undergoing examination and any care including adjustment, exercise and/or traction. Adjustments require forces to move skeletal bones and as such puts stress on blood vessels, bones, discs, nerves and soft tissue. The below are some of the more serious risks but it is not an exhaustive list:

A) **RARE BUT SERIOUS RISKS:** Damage to blood vessels, bones, discs or spinal cord may lead to death, stroke, paralysis or permanent injury

B) **MORE COMMON BUT LESS SERIOUS RISKS:** Sprains, strains, rib fractures, bruising inflammation and soreness.

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I (the undersigned) do not expect the doctor to be able to anticipate and explain all the risks and complications. I (the undersigned) also understand that results are not guaranteed.

**Consent for x-rays**: x-rays are taken when indicated to access spinal biomechanics and the integrity of osseous and soft tissue structures.

**Females only - Pregnancy Release:** x-rays can be hazardous to an unborn child. In signing below I consent to x-ray evaluation and certify that to the best of my knowledge I am not pregnant.

In signing below I acknowledge that I have been given opportunity to ask further questions about the spinal examination and spinal x-rays. I also intend this consent form to cover the entire course of treatment for my present condition, and for any other future condition(s).This consent can be withdrawn at any time.

**I, the undersigned, hereby consent to chiropractic x-rays if required and chiropractic treatment by Dr William Logan, and/or any other chiropractor working in this clinic authorised by Dr William Logan for myself or the minor/dependant stated below.**

Patient name: Signature:

***If applicable -*** Carer’s Name: Carer’s Signature:

Dr William Logan signature: Date: / /