

Welcome to Body & Brain Centre!

Date: _____

Name: _____ DOB: _____ Age: _____

Mum's Name: _____ Dad's Name: _____

Siblings' Names & Ages: _____

Address: _____ Suburb: _____ Postcode: _____

Mum's Mobile: _____ Dad's Mobile: _____ Preferred Contact: _____

Email Address: _____

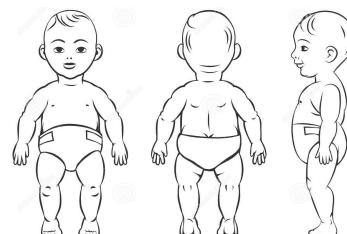
Please Tick: I would like to receive newsletters with special offers, health tips and more.

Who can we thank for referring you? Sign BodyBrainCentre Website Google Facebook
 GP Other Practitioner Patient Name of Dr or Patient: _____

Has your child had previous care from Chiropractor Physiotherapist Speech Pathology
 Occupational Therapist Psychologist Paediatrician

For What: _____

Please describe your present condition/s, **how** and **when** it started & mark on the diagram (if relevant):



Pregnancy

Did You / the Mother Experience Any? Falls Accidents Significant emotional stress
 Illness (Ectopic Pregnancy, Gestational Diabetes, High Blood Pressure, Placenta Previa, etc)
 Morning Sickness / Hyperemesis Gravidarum Exposure to Toxins (Alcohol, Drugs, Tobacco)
 Fears about Health / Survival of your Child Back or Pelvic Pain / Discomfort Good Health
Details / Other: _____

Birth

Where was your child born? _____

How long was the labour? From time of first contraction until birth _____

How Many Weeks? _____ Birth Weight: _____ Birth Length: _____

APGAR Score: 1 Minute: ____/10 5 Minutes: ____/10 Unknown Unknown except it was low

How was your Child Delivered? Vaginal Caesarian (planned) Caesarean (emergency)

How did your Child Present? Crown / Top of Head First Face First Breach Other (detail)

Were any Interventions Used? Epidural Induction Forceps Suction Other (detail)

Details: _____

According to your midwife / obstetrician, did your child become distressed at any time?

Physical

Chiropractic
Myotherapy
Remedial Massage

Brain

Biofeedback
Neuro-Rehab
Brain Scans

Emotional

Counselling
Meditation

Nutritional

Dietetics/Nutrition
Naturopathy

Traditional

Acupuncture
Chinese Medicine

Infant / Toddler History

Was the Child Breastfeed? Yes No If Yes, For How Long? _____

At What Age Did Your Child:

_____	Respond to Sound	_____	Crawl
_____	Follow Object	_____	Walk
_____	Hold Head Up	_____	Say mamma / dada
_____	Vocalise Noises	_____	Combines two words
_____	Sit Alone	_____	Speaks in Sentences

Overall Health

Has Your Child Had or Having Problems with:

Past	Current	N/A		Past	Current	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema / Skin Conditions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breastfeeding Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Intolerances
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to Light, Touch, Noises
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Growing Pains
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colic
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Co-Ordination / Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moodiness / Tantrums
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attention Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Language Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Counting Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Separation / other anxiety

What is your Child's Hobbies and Interests? _____

Does your Child Attend Daycare or Kinder? Yes No Where? _____

Has Your Child Experienced Any: Falls Accidents Fractures / Dislocation Surgeries
 Significant Hardship / Stress and When They Occurred

Details: _____

Has Your Child Been Diagnosed with any Condition, Disorder or Disability Not Previously Mentioned? _____

Is Your Child Up to Date with Their Vaccinations? Yes No

Please list Your Child's Medication (including Supplements):

Current: _____ Previous: _____

Is there a Family History of any Major or Recurring Illness / Diseases? Eg: heart attack, cancer, anxiety, depression, dementia, diabetes, thyroid, seizures, learning difficulties, behaviour conditions, allergies / intolerances

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Informed Consent For Chiropractic Examination and Treatment

Your child's individualised chiropractic consultations may consist of the following:

1. **Physical Examination:** The examination, prior to any treatment, may exacerbate your child's condition or cause some fussiness.
2. **Gentle mobilisations of the spine, extremities (arms & legs) or cranium:** Gentle pressure or stretches may be used to relieve tension and promote normal movement patterns. Additional low force techniques such as cranials, blocking / mechanical wedges, drop piece-assisted adjustments or Activator ("clicker"). Rarely mild adverse reactions occur (0.53 - 1%) including irritability or soreness lasting less than 24 hours.
3. **Massage and Soft Tissue Techniques:** Skin irritation, bruising / redness, minor discomfort, aching or fatigue are possible risks.
4. **Electrical Stimulation:** Mostly commonly, a tingle, itch, slight sting or forceful muscle contraction is felt. Infrequently, burns from improper settings or allergic reaction to electrodes are possible.
5. **Taping:** Sometimes result in skin irritation, minor discomfort or infrequently, an allergic reaction.
6. **Home exercises:** Overdoing or using incorrect technique may result in an exacerbation of your child's symptoms or cause fatigue. Always ask if unsure of any home advice.
7. **Supplements and / or dietary advice:** Gastrointestinal discomfort or disturbances (constipation, diarrhoea), skin rash and potential for drug interactions.
You are under no obligation to purchase supplements through BCC. We offer carefully selected products which are high in quality active ingredients for your convenience.

Other treatment options include, but is not limited to, pharmacological interventions (painkillers, anti-inflammatories or other medication), surgery, bracing / rest or management with other manual therapists. These also have associated possible risks. Please discuss these options with your treating practitioner and / or general practitioner for more information.

The risk of remaining untreated or delaying treatment include developing long term musculoskeletal complications, pain or prolonging development of the nervous system. An immature nervous system can have effects on how a child learns, socialises and moves.

Research studies and presentations are performed from time to time within BBC. This assists us deliver the best quality care and to educate fellow practitioners. All information which identifies you and your child will be remove. Your involvement will not affect your management plan. Participation is voluntary and consent may be revoked at any time.

PLEASE DO NOT SIGN UNTIL YOU HAVE SPOKEN TO YOUR CHIROPRACTOR.

I have read the above and acknowledge I am aware of and understand the potential risks. I do not expect the chiropractor to be able to anticipate or explain all the risks and complications. I wish to rely on the chiropractor to exercise her/his judgement during the course of the procedures which she/he feels, at the time, based upon the facts known, is in my best interests.

I have had the opportunity to discuss with the chiropractor and ask questions about the nature and purpose of the examination and treatment and all of my concerns. I understand that results are not guaranteed.

Please tick

- The information provided is accurate and fully inclusive to the best of my knowledge. I understand the advice and treatment plan is made on the information that I provide. I will update my practitioner on any medical conditions or health concerns as they arise.
- I hereby request and consent to chiropractic examination and management of my child. I understand that I can withdraw my consent at any time.
- I hereby consent for my child's de-identified information to be used in research and presentations.
- I consent to information being sent to third parties when I have authorised it (eg: private health insurance)
- I understand I must provide 24 hours notice if I'm unable to attend my scheduled appointment to avoid paying a 50% cancellation fee. If I fail to provide notice that I cannot attend my appointment, I will be liable for 100% of the consultation fees. I also understand that all fees are payable on the day of consultation.

I, _____ (Parent / legal guardian's name), am the legal guardian of _____ (child's name) and consent to his / her care.

SIGNATURE _____ DATE _____

CHIROPRACTOR'S SIGNATURE _____ DATE _____

(Own behalf of any current or future doctors of chiropractor of Body and Brain Centre)

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