

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: _____

Email Address: _____

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

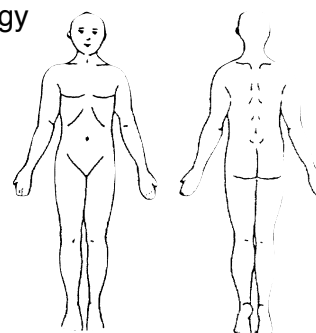
Who can we thank for referring you? _____ PS they will get a thank-you voucher

If online, what search words were used? _____

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

For What: _____

Please describe your present condition/s, how 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: _____

Was your Child in a Hospital Crib after Delivery? Yes No

If known, APGAR Score: 1 minute _____ / 10 5 minutes _____ / 10 Unknown

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?

Chiropractic ● Remedial Massage ● Myotherapy ● Cupping & Dry Needling

Neuro Rehabilitation ● QEEG Brain Scans ● Dietetics / Nutrition ● Meditation ● Counselling ● Pilates

Infant / Toddler History

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

Did Your Child Have Any Developmental Delays: Yes No **Details:** _____

Describe Your Child's Steps in Learning to Walk Eg: commando crawling —> cruising along furniture —> Frankenstein walking. Feel free to be descriptive. **Please include any ages you recall for each milestone** Eg: crawling at 7 months.

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 (terrors, walking, etc)
<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"/>	Restless Legs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Co-Ordination / Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Accident Prone Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colic
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Learning Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moodiness / Tantrums
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attention Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tics / Twitches / Tourettes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reading or Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Messy Handwriting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arithmetic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social Difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Separation Anxiety

What is your Child's Hobbies and Interests? _____

Where does your Child Attend Kinder or School? _____ **Grade:** _____

Has your Child Been: Expelled / Suspended Repeated Grades Been Tutored Attended Special Classes (eg: reading recovery) **Subjects:** _____

Has Your Child Experienced Any: Falls Accidents Fractures / Dislocation Sprains Surgeries / Hospitalisations Significant Hardship / Stress **and When They Occurred**
Details: _____

- Chiropractic ● Remedial Massage ● Myotherapy ● Cupping & Dry Needling
- Neuro Rehabilitation ● QEEG Brain Scans ● Dietetics / Nutrition ● Meditation ● Counselling ● Pilates

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

How do you rate your child's: General wellbeing ____/10 **Why?** _____

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

Does Anyone In the Household: Smoke Drink more than 7 drinks of alcohol per week

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. If anything causes pain, we will discontinue but note it to make an accurate diagnosis.
2. **Non-trust mobilisations of the spine, extremities (arms & legs) and / or cranium:** Gentle pressure or stretches may be used to relieve tension and promote normal movement patterns. No known adverse reactions.
3. **Low force joint mobilisations of the spine, extremities (arms & legs) and / or cranium** including gentle cranial massage, blocking / mechanical wedges, drop piece-assisted adjustments or Activator ("clicker"). No known adverse reactions.
4. **Gentle manual adjustments of the spine and / or extremities (arms & legs):** Rarely (0.53 - 1%) mild adverse reactions occur including irritability or tenderness lasting less than 24 hours.
5. **Massage and soft tissue techniques:** Some people experience some skin irritation such as redness or bruising, minor discomfort / ache or fatigue after muscles, tendons and other soft tissue structures are worked on.
6. **Electrical stimulation:** A very low current can be used to relax tight muscles or activate 'lazy' muscles. 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.
7. **Laser:** Low level laser therapy is a medical-grade treatment instrument which uses a light beam to reduce inflammation and promote tissue healing. The laser doesn't produce any sensation or occasionally a slight heating sensation may be felt. The scientific literature doesn't report any adverse reactions, but to be extra cautious we wear protective eyewear. Infrequently, a mild ache be experienced in the following 24 - 48 hours.
8. **Taping:** Sports tape can be applied to the skin to help facilitate muscle contractions and re-educate movement patterns as well as being used to support unstable joints. Sometimes taping can result in skin irritation, minor discomfort or infrequently, an allergic reaction to the tape.
9. **Home exercises:** Home exercises are important for maintaining the results achieved in your child's appointments. 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.
10. **Supplements and / or dietary advice:** When dietary advice or supplements are prescribed to assist your child's healing, growth and development, it may result in 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.

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Other treatment options include, but is not limited to, pharmacological interventions (pain killers, anti-inflammatories or other medication), surgery, bracing / rest or management with other manual therapists. Adherent risks include, but is not limited to, irritation of the stomach, liver or kidneys and dependence issues to medication; and infection, adverse reactions to anaesthetic or extended recovery times after surgery or hospitalisation. 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. There are no additional risks associated with being involved in BBC collecting your de-identified clinical information.

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% cancelation fee. I also understand that 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)