Welcome to Body & Brain Centre!

Date: _____

Name: _____ **DOB:** _____ **Age:** _____

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

Siblings' Names & Ages: _____

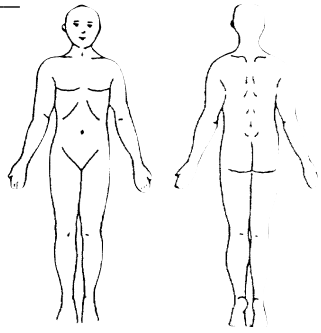
Address: _____ **Suburb:** _____ **Postcode:** _____

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? _____



Presenting Complaint

Please describe your present condition/s, how it started & mark on the diagram (if relevant):
Condition 1: _____
_____
Condition 2: _____
_____
Condition 3: _____
_____

	When Did it Start? Date or days, months, years	**How Often do you Feel it?** 0% = never, 100% = always	**How Long Does it Last?**	**Progress:** Getting worse? Constant? Improving?	**When is it worst?** Waking up, night time, after sitting	**Pain** 0 = no pain, 10 = worst pain
Condition 1						Average: ___ Worst: __ /10 Best: ___ /10
Condition 2						Average: ___ Worst: __ /10 Best: ___ /10
Condition 3						Average: ___ Worst: __ /10 Best: ___ /10

Continue from front…	**Improves with** … Medication, ice, heat, movement, rest, nothing	**Worse with** … Coughing, sneezing, bending, sitting, inactivity, left rotation, etc
Condition 1		
Condition 2		
Condition 3		

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

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

How Many Weeks? _____ **Was your Child in a Hospital Crib after Delivery?** ❒ Yes ❒ No

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: _____

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.
_____
_____

School / Educational Background

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

Has your Child Experienced any Learning Difficulties? ❒ Yes with details below ❒ No

Has your Child Experienced any Behavioural Difficulties? ❒ Yes with details below ❒ No

Details: _____
_____

What's Your Chid's Favourite Subject(s)? _____
Least Liked Subject(s)? _____

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

Pubescent Health

What was the First Sign of Puberty (if any) and When? _____

When was your Child's Last Growth Sport? _____ **How Much Growth?** _____ cm

Has your child had their first period? ❒ No ❒ Yes **If yes, please answer the following:**
How old were they? _____ **Average Cycle Length:** _____ **Days of Bleeding:** _____
How heavy is it measured by pads / tampons used daily? ❒ 1 - 2 ❒ 3 - 4 ❒ 5 - 8 ❒ 9 -10 ❒ 11+
What (if any) PMS symptoms does your child experience?_____
_____

Please Tick which Pubescent Changes Your Child Has Experienced:

❒ Breast development ❒ Underarm & body hair ❒ Increased sweat production

❒ Pubic hair ❒ Oily skin ❒ Moodiness

Overall Health

Has Your Child Had or Having Problems with:

Past	Current	N/A		Past	Current	N/A	
❒	❒	❒	Bowels	❒	❒	❒	Eczema / Skin Conditions
❒	❒	❒	Breastfeeding Difficulties	❒	❒	❒	Allergies / Intolerances
❒	❒	❒	Bedwetting	❒	❒	❒	Sleep (terrors, walking, etc)
❒	❒	❒	Recurrent Bladder Infections	❒	❒	❒	Sensitivity to Light, Touch, Noises
❒	❒	❒	Recurrent Throat Infections	❒	❒	❒	Growing Pains
❒	❒	❒	Recurrent Ear Infections	❒	❒	❒	Restless Legs
❒	❒	❒	Reflux	❒	❒	❒	Headaches
❒	❒	❒	Co-Ordination / Movement	❒	❒	❒	Scoliosis
❒	❒	❒	Accident Prone Child	❒	❒	❒	Colic
❒	❒	❒	Learning Difficulties	❒	❒	❒	Moodiness / Tantrums
❒	❒	❒	Attention Difficulties	❒	❒	❒	Epilepsy / Seizures
❒	❒	❒	Hyperactivity	❒	❒	❒	Tics / Twitches / Tourrettes
❒	❒	❒	Reading or Comprehension	❒	❒	❒	Asthma
❒	❒	❒	Messy Handwriting	❒	❒	❒	Sinus
❒	❒	❒	Arithmetic	❒	❒	❒	Social Difficulties
❒	❒	❒	Anxiety	❒	❒	❒	Separation Anxiety
❒	❒	❒	Chicken Pox	❒	❒	❒	Eating Disorders
❒	❒	❒	Risky Behaviour	❒	❒	❒	Confidence Issues

What is your Child's Hobbies and Interests? _____

_____

Has Your Child Experienced Any: ❒ Falls ❒ Accidents ❒ Fractures / Dislocation ❒ Sprains ❒ Surgeries / Hospitalisations ❒ 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):

_____

Is there a Family History of any Major or Recurring Illness / Diseases? _____

_____

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 any discomfort, 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. This includes cranial therapy, sacra-occipital technique (SOT) blocking / mechanical wedges, drop piece adjustments and / or Activator ("clicker"). No known adverse reactions.
3. **Gentle manual adjustments of the spine and / or extremities (arms & legs):** Infrequently, mild adverse reactions occur (0.53 - 1%) including irritability or soreness lasting less than 24 hours. Extremely rarely more complex reactions can occur such as sprain, strains, fractures and damage to blood vessels.
4. **Massage and soft tissue techniques:** Tight points in the muscles may feel a bit uncomfortable to touch, massage and stretch. Some people are left with bruising or redness, an ache or fatigue.
5. **Taping & Electrical stimulation:** Mostly commonly, electrical stimulates feels like a tingle, itch, slight sting or forceful muscle contraction whilst taping may be felt as restricting certain movements. Occasionally, skin irritation or minor discomfort may be felt and less commonly, improper settings of the electrical stimulation can cause minor burns.
6. **Laser:** Laser therapy can be used to heal tissues and reduce inflammation. The probe may feel cold against the skin, however the actual laser does not cause any sensation. There are no adverse reactions and to be extra cautious we use protective glasses (like going to the dentist).
7. **Home exercises:** Home exercises are important to sustain changes achieved in treatment sessions. These are very safe however overdoing or using incorrect technique may result in an exacerbation of your child's symptoms or cause fatigue. Always ask if unsure.
8. **Supplements and / or dietary advice:** Most supplements will make you feel better with the results targeted towards your health, such as more energy, decreased pain or better learning. Sometimes, people notice that they feel a little ill afterwards or that they experience constipation, diarrhoea or skin redness. Supplements can affect any medication you are taking so it's important to discuss this with your Chiropractor.

Other treatment options include, pain-killers & other medication, surgery, bracing / rest or management with other manual therapists. These all carry their own risks (eg: organ damage & extended recovery time).

The risk of remaining untreated or delaying treatment include developing long term musculoskeletal complications 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 within BBC. This assists us deliver the best quality care & to educate fellow practitioners. All information which identifies you will be remove. Your involvement will not affect your management plan. Participation is voluntary & 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.

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 & consent to chiropractic examination & management of my child.

☐ I hereby consent for my child's de-identified information to be used in research & 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_____
(Own behalf of any current or future chiropractors at BBC)