CHILD INTAKE FORM

Dear Patient: Please complete this questionnaire. Your answers will help us determine if our services can help you and devise the most effective treatment plan. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU!

CHILDS NAME: DOB:

AGE: M/F:

PARENTS NAMES:

SIBLINGS NAMES & AGES:

ADDRESS:

HOME # : WORK #:

MOB # : EMAIL:

Who may we thank for recommending you to our clinic?

HEALTH OBJECTIVES

How would you like us to handle your treatment? | Please tick one

- ☐ Temporary symptomatic relief only
- ☐ Care to allow healing to take place & temporary symptomatic relief
- ☐ Wellness care to help prevent the problem recurring in the future including, care to allow healing to take place & symptomatic relief

CHILDS HEALTH CONCERNS

Give reasons for seeking care:

1.

2.

3.

When and how did this problem start?

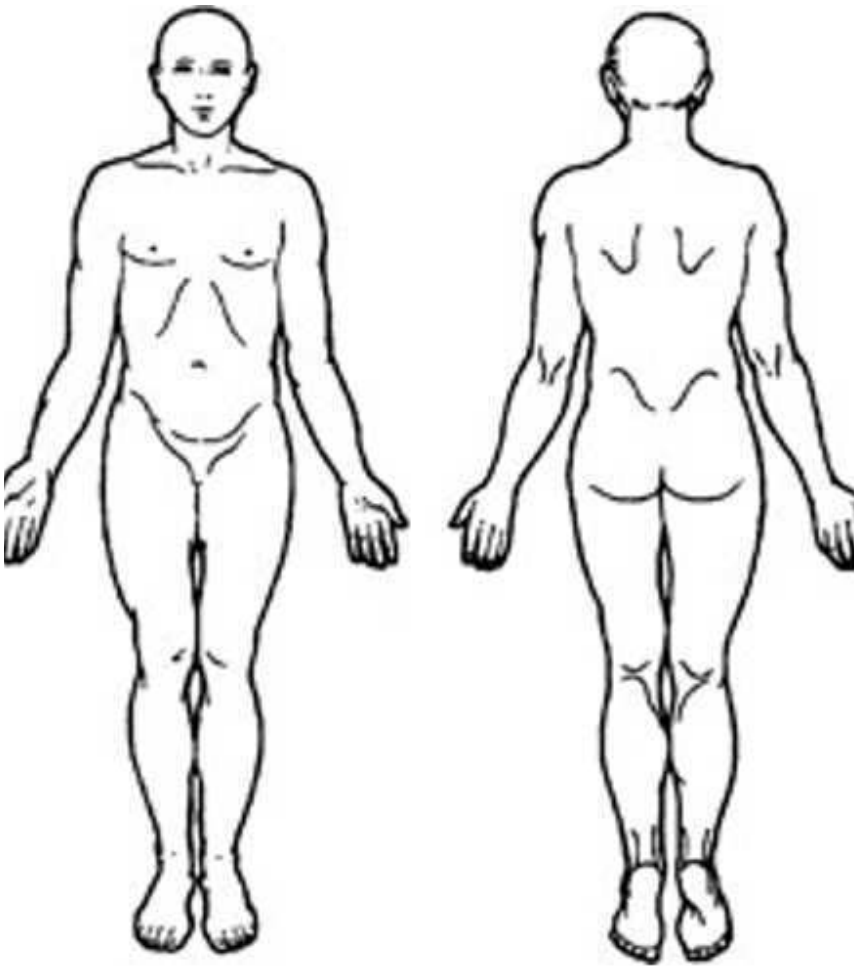
Is it getting: better / worse / more frequent / other?

Is the problem worse at any time of the day? AM / PM

If your child has pain please rate it on a scale of 1 -10:

Type of Pain: Sharp / Dull / Throbbing / Achy / Shooting / Burning / Pins & Needles

Please indicate below the areas of the body where you experience symptoms/pain:



CURRENT MEDICINES AND SUPPLEMENTS

Please list any medications/drugs your child has taken in the past 6 months and why (prescription and non-prescription:

Please list all nutritional supplements, vitamins, homeopathic remedies your child presently takes and why:

Has your child ever had X-rays, MRI's, CT scans or Ultrasounds taken? Y / N If yes, please provide details:

Does your child wear orthotics or heel lifts? Y / N

PRACTITIONER HISTORY

Has your child had Chiropractic care before? Y / N If yes, please describe:

Has your child ever received Chiropractic manual adjustments before? Y / N

Name of Practitioner:

Date of last Chiropractic care:

Name of G.P:

Date of last G.P. visit:

FAMILY HEALTH HISTORY

Many health problems are the result of hereditary spinal weakness, thus information about your family members will give us a better picture of your total health picture.

Has anyone in your immediate family (including Uncles, Aunts and Grandparents) had any of the following?

Heart Disease Y /N

Arthritis Y / N

Thyroid issues Y / N

Diabetes Y / N

Neurological Y / N

Cancer or any other condition Y / N

CHILDS HEALTH HISTORY

Pregnancy:

Any illnesses during pregnancy:

Any medication taken during pregnancy:

Any complications during pregnancy:

The birth of your child can give vital clues as to potential spinal problems.

- ☐ Home / Hospital delivery
- ☐ Drugs during delivery
- ☐ Delivered normally
- ☐ Breech
- ☐ Posterior
- ☐ Late
- ☐ At term
- ☐ Caesarean (please explain)
- ☐ Premature (how many weeks?)
- ☐ Forceps
- ☐ Chemically induced
- ☐ Suction

Other:

Birth weight in kgs:

APGAR scores:

How many hours were you in labour:

Do you believe the birth was traumatic for your child?

Was your child's head misshaped at birth?

Were there any delivery complications?

Other:

Birth to six months:

Was your child breastfed? If so for how long?

Any difficulties breast-feeding? If yes please explain.

Were there attachment issues? If yes please explain.

Was your child formula fed? If yes for how long?

Did your child suffer with colic? If yes mild/moderate/severe?

Did your child suffer with reflux? If yes mild/moderate/severe?

At what age was your baby introduced to solids?

At what age was your baby introduced to cows milk?

Is your child allergic or intolerant to any food? Y / N If yes, please explain:

Is your child sensitive to/bothered by any of the following?

- ☐ Perfumes/Cosmetics
- ☐ Animals
- ☐ Ice cream
- ☐ Peanuts/Nuts
- ☐ Cleaning products
- ☐ Soaps
- ☐ Detergents
- ☐ Dust
- ☐ Chlorine water
- ☐ Mould
- ☐ Biscuits
- ☐ Bread/wheat
- ☐ Egg
- ☐ Sugar
- ☐ Milk
- ☐ Oranges
- ☐ Veges
- ☐ Pollen
- ☐ Sunlight/Bright light
- ☐ Fabrics
- ☐ Washing powders
- ☐ Insects
- ☐ Birds
- ☐ Pasta
- ☐ Red Meat
- ☐ Fruit Juices
- ☐ Other

Does your child have food cravings? If so what?

Please indicate the most appropriate description of your child's diet:

- ☐ Breast Milk/Formula
- ☐ Mostly baby foods
- ☐ Mostly meat
- ☐ Mostly carbs (bread, pasta etc)
- ☐ Pre-packaged/microwave
- ☐ Sweet/sugary foods
- ☐ Mostly vegetarian
- ☐ Takeaway/fast food
- ☐ Mostly dairy (milk, cheese)
- ☐ Only eats 1 - 3 types of food

Other, please describe:

Would you say your child was a:

- ☐ Very poor sleeper
- ☐ Poor sleeper
- ☐ Average sleeper
- ☐ Good sleeper
- ☐ Very good sleeper

How many hours does your child sleep on average:

What times:

Social History:

Who lives at home with your child?

Pets at home:

Is your child involved in sports, music or other activities?

How does your child interact with other people? ie: children, adults etc

Developmental History:

Please list age when the following skills were mastered, and any problems associated:

Pull to stand:

Sitting up:

Crawling:

Walking:

Uttering single words:

Forming sentences:

Jumping

Running:

Current Health:

Has your child ever been assessed for the presence of scoliosis?

Is your child accident prone?

Has your child had any significant falls?

Please list any past accidents and dates:

Please list any past surgeries and dates:

Please list any diseases/illnesses:

Please indicate the following conditions your child may have had or have now:

- ☐ Dizziness
- ☐ Memory Loss
- ☐ Thyroid issues
- ☐ Anxiety
- ☐ Impotence
- ☐ Diarrhea
- ☐ Inattention
- ☐ Asthma
- ☐ Knee Pain
- ☐ Shoulder Pain
- ☐ Menopausal
- ☐ Sinus trouble
- ☐ Migraines
- ☐ Fatigue
- ☐ Allergies
- ☐ Eye Issue
- ☐ ADD / ADHD
- ☐ Low Blood Sugar
- ☐ Hyperactivity
- ☐ Recurrent Infections
- ☐ Constipation
- ☐ High Blood Pressure
- ☐ Low Back Pain
- ☐ Ringing in Ears
- ☐ Skin Conditions
- ☐ Painful Periods
- ☐ Chemicals exposure
- ☐ Depression
- ☐ Insomnia
- ☐ Bloating
- ☐ Gas
- ☐ Ear Issue
- ☐ Headaches
- ☐ Weight Gain/ Loss
- ☐ Poor Concentration
- ☐ Heart Palpitations
- ☐ Neck Pain
- ☐ Difficult Digestion
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Difficulty Urinating
- ☐ Shortness of Breath
- ☐ Irregular Periods
- ☐ Reproductive issues
- ☐ Nausea
- ☐ Fainting
- ☐ Stress

Is there any other issue that concerns you that has not been discussed?

AGREEMENT & FEES

1st Visit (Initial Consultation & Exam):	$190
2nd visit (Reports/Extended Visit):	$160
Standard Visit:	$120
Missed Appointment:	50% of fee

Please read the following carefully:

1. Changes to the law now require all practitioners who manipulate the spine to warn patients of material risks. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to a stroke or stroke-like symptoms (approx.1 in 5.85 million) [Neck manipulations. Halderman, et al Spine vol 24-8 1999]. Whilst this has never occurred in this practice, we are still required to warn. If any adjustments (manipulations) are required, you will be tested beforehand, as has always been our practice.

2. Other very slight risks include strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 174,000) [Dvorak, J Man Med 1989; 4:7-16]. Chiropractic adjustments of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medication and many other alternatives [A Risk Assessment of Cervical Manipulation, JPMT 1995, Manga Report, Ontario Ministry of Health 1993].

3. I Hereby request and consent to the performance of Chiropractic adjustments, other Chiropractic procedures and if necessary diagnostic x-rays on me by the Chiropractor named below and/or anyone authorised by the same Chiropractor.

4. I further understand and am informed that, as in all health care, there are some slight risks to treatment and do not expect the Chiropractor to be able to anticipate or explain all risks and combinations: and wish to rely on the Chiropractor to exercise judgement during the course or the procedure which the Chiropractor feels at the time based upon facts known, is in my best interest.

5. I further understand that Chiropractic care cannot guarantee resolution of some or all of my ailments.

In addition, we try very hard to accommodate all our patients with suitable days and times for appointments and we therefore ask that you honour these times that have been set aside for you or your child. If an appointment is missed or cancelled within 24 hours before the appointment, a charge of 50% of your scheduled fee will be applied.

The statements made on this form are accurate, to the best of my recollection, and I agree to allow this office to do an examination of me for further evaluation.

Patients signature (parent or guardian to sign if patient is under 18):		Chiropractors signature:	
Patients name (printed):		Dated:	

NEURO EMOTIONAL TECHNIQUE
INFORMED CONSENT:

The effect of emotions on health is well documented in scientific literature and for over 100 years Chiropractors have attributed emotions to being one of the three causes of misaligned vertebra (a vertebral subluxation). Neuro Emotional Technique (NET) was developed in 1988 to treat vertebra that misalign/subluxate in an acquired reflex to unresolved emotional triggers.

NET is an interactive process that requires the Patient's participation. The Chiropractor is merely the facilitator. The NET process establishes the stuck (unresolved) emotion relating to an original event or experience, by determining weakness in the Patient's acupuncture meridian system and the body's response to particular words.

To release the unresolved emotion, the Chiropractor will contact, or ask the Patient to contact particular body points while the Patient pictures the original event or experience. Needles are NOT used.

NET does not deal with Reality but with Emotional Reality. Any conceivable life experience may be the subject of an unresolved emotion. Such experiences may include but are not limited to those appearing on the bottom of this page.

The Patient is in complete control and can discontinue the treatment if any topic arises which the patient does not wish to discuss. Occasionally Patient's may become emotional during or after an NET treatment. This is perfectly normal and can be likened to the purging effect of coughing or sneezing. Appropriate referrals to other Health Care Professionals are made where appropriate.

NET is a highly specialised technique requiring significant training. Should you be provided with an opinion on NET by any Health Care Professional who is not trained in NET please contact this Clinic immediately.

I have been provided with a brochure entitled 'What Patients Want to Know About Neuro Emotional Technique' or have been recommended to visit and read the NET website: www.netmindbody.com and have clarified queries with the attending Chiropractor.

I give my consent for Chiropractors of Better Balance Chiropractic to use the skills necessary to examine and care for me each time I consult them.

Patients signature (parent or guardian to sign if patient is under 18): _____ Dated: _____

Patients name (printed): _____

Chiropractors signature: _____ Dated: _____

Topics that may arise during an NET treatment:

Any conceivable life experience may be the subject of an NET treatment. Topics may include but are not limited to the following:

Abortion	Eating Disorders	Mortality / Death	Sexual Experience
Abuse of any kind	Ethnicity	Phobias	Spirituality
Adultery	Failure / Success	Rape / Trauma	Self Image
Addictions	Love / Intimacy	Religion	Violence