shambrook
FAMILY CHIROPRACTIC

Age 12 - 17
New Patient Registration

INCLUDING CONSENT TO TREAT A MINOR
Please Print

Child Patient Name | Today's Date

Date of Birth; | Age:

Parent Name(s): | Are they the child's guardian? ☐ Yes ☐ No

If no, name of guardian(s)

Names & ages of siblings

Address | Town/City | Postcode

Home Ph | Business Ph | Mobile

Health Fund

Who referred you to our clinic?
☐ Friend or Acquaintance (name): _____
☐ Family member (name): _____
☐ Another Health Professional (please specify) _____
☐ Our Signage
☐ Website
☐ Advertising
☐ Location
☐ Facebook
☐ Other (please specify): _____

Major Complaint

How long has this condition existed?

Is it getting? ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better

Previous diagnosis/treatment for this condition

Other complaints

On any medication/Supplements?

List any surgery, accidents or falls

Any previous Chiropractic care & when | For how long? | Date of last Adjustment

Any spinal x-rays & when | Chiropractic doctor & location

Does your child play sport? | How many times per week?

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Birth Process

Was the delivery long	☐ Yes	☐ No
Was the delivery difficult	☐ Yes	☐ No
Forceps / vacuum extraction	☐ Yes	☐ No
Head bruising	☐ Yes	☐ No
Caesarean	☐ Yes	☐ No
Breach	☐ Yes	☐ No
Induced labour	☐ Yes	☐ No
Drugs during labour	☐ Yes	☐ No
Drugs during delivery	☐ Yes	☐ No

As a Baby

Was breastfed	☐ Yes	☐ No
Was a headbanger	☐ Yes	☐ No
Fell on head	☐ Yes	☐ No
Fell down stairs	☐ Yes	☐ No

Has or does child have problems with

Bowels	☐ Yes	☐ No
Bedwetting	☐ Yes	☐ No
Recurrent bladder infections	☐ Yes	☐ No
Recurrent throat infections	☐ Yes	☐ No
Recurrent ear infections	☐ Yes	☐ No
Co-ordination	☐ Yes	☐ No
Learning difficulties	☐ Yes	☐ No
Attention deficit disorder	☐ Yes	☐ No
Sinus	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Restless legs	☐ Yes	☐ No
Growing pains	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Migraines	☐ Yes	☐ No
Moodiness	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Asthma	☐ Yes	☐ No

List date of last

Physical examination

Blood test

Chest X-ray

Urine test

Name of medical doctor

Location

For Females Only

When did your last period start?

Are you pregnant? ☐ Yes ☐ No ☐ Maybe

Do you experience painful menses? ☐ Yes ☐ No

Is your menses irregular? ☐ Yes ☐ No

Has the child been treated for

☐ Diabetes	☐ Arthritis
☐ Thyroid	☐ Scarlet Fever
☐ Rheumatic Fever	☐ Cancer
☐ Tuberculosis	☐ Cold Sores
☐ Anemia	☐ Pneumonia
☐ Diptheria	☐ Stroke
☐ Mumps	☐ Glandular Fever
☐ Appendicitis	☐ Allergies
☐ Eczema	☐ High Blood Pressure
☐ Measles	☐ Attention Deficit Disorder
☐ Polio	☐ Migraines

Psychosocial any recent occurrence

Depression	☐ Yes	☐ No
Death (Family / Friends)	☐ Yes	☐ No
Divorce / Separation	☐ Yes	☐ No
Family Problems	☐ Yes	☐ No
Sleep Disturbances	☐ Yes	☐ No

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Family Health History Many health problems are the result of hereditary spinal weaknesses. This information will give us a better picture of the child's total health. List family members who have had any health problems such as migraines, strokes, heart disease, blood diseases, arthritis, spina bifida etc.

Relationship to Child	Past or Present Health Problems

CONSENT TO TREATMENT AND EXAMINATION OF A MINOR

I hereby authorise the doctors at Shambrook Family Chiropractic and whomever they may designate as their assistants to administer chiropractic care as deemed necessary to my child. I hereby also consent to the performance of a chiropractic assessment by the chiropractor including physical, neurological and orthopaedic tests. This may include reflexes, range of movement and the taking of a series of postural photos and X-rays.

_____

Name of Child

_____

Signature of Parent (or Guardian) Today's Date

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