Natural Health Works ph: 1800 60 10 36 www.naturalhealthworks.com.au

Paediatric Initial Treatment Application

Please Print Clearly in block letters!

Personal Information

Name _____ DOB _____

Address _____

Suburb _____ Postcode _____

Ph(H) _____ Ph(M) _____ Ph(W) _____

Email _____

Marketing Information - Please fill in as much or as little as you wish in this section

How did you hear about us?

☐ Professional Referral _____

☐ Friend (We'd like to thank them!) _____

☐ Newspaper (Which?) _____

☐ Poster (Where?) _____

☐ Mail ☐ Website ☐ Approached by Staff ☐ Information Stall ☐ Radio/TV

☐ Other (Please Specify) _____

Do you have any advice/suggestions/feedback on NHW marketing activites? _____

_____

_____

Please note that NHW does not provide financial incentives for referrals, however we do encourage you to tell your friends about us. Please let us know if you would like some material you can pass on. Alternatively, if there is someone you believe we should call, please feel free to list their names and contact details here: _____

_____

_____

_____

_____

_____

Personal Health History

Please fill out the following questionnaire. Please do not feel embarrassed by how much or how little you put down, please just do your best to give an accurate report of where your child's health is at right now. This will help us to provide your child with better care, and it will help you to track their health as it improves.

Healthcare Outcomes

Which areas are you looking for care in?

- ☐ Physical Symptom Relief
- ☐ Emotional/Mental Symptom Relief
- ☐ Improved Health/wellbeing
- ☐ Learning difficulty
- ☐ Food intolerances
- ☐ Children - Behavioural
- ☐ Children - Developmental
- ☐ Improved Posture
- ☐ Greater Energy Levels
- ☐ Attention span

Primary Complaint

Please note any issues that are of particular concern here

What is your main area of concern?_____

_____

_____

When did this problem start?_____

Do you know what caused the problem?_____

What makes it better?_____

What makes it worse?_____

How often do you have symptoms? ☐ Daily ☐Weekly ☐Monthly ☐Occasional

Have you had other treatments?_____

Are there any other major issues you would like help with, or that your practitioner should know about?_____

_____

_____

_____

Current Health Scores and History

Do you experience any of the following? (P=past, C=current)

P	C		P	C	
☐	☐	Any attention deficit symptoms	☐	☐	Difficulty falling asleep
☐	☐	Nightmares	☐	☐	Difficulty staying asleep
☐	☐	Bedwetting	☐	☐	Anxiety/Depression
☐	☐	Headaches	☐	☐	Blood Sugar Problems
☐	☐	Migraines	☐	☐	Poor Digestion
☐	☐	Vision problems	☐	☐	Nausea or Constipation
☐	☐	Trouble talking	☐	☐	Diarrhoea
☐	☐	Difficulty Breathing	☐	☐	Difficultly retaining information
☐	☐	Finger/thumb sucking	☐	☐	Skin Problems
☐	☐	Hyperactivity	☐	☐	Vaccine reactions
☐	☐	Interruption to family dynamics	☐	☐	Problems at daycare/school
☐	☐	Stress with daily activities	☐	☐	Mood swings
☐	☐	Poor Balance/Co-ordination	☐	☐	Colic
☐	☐	Poor/Variable muscle strength	☐	☐	

Please List All allergies:_____

_____

_____ ☐ None

Was the pregnancy – Easy Difficult Morning sickness Complications

Was the birth - Premature Due date Late Details:_____

Birth - Spontaneous labour Vaginal Induced Planned caesarean Emergency Caesarian Drugs used

Breastfed - Yes No If yes, how long:_____

Introduction to solids - Age:_____ Foods introduced:_____

Vaccinated - Yes No

History of infections/medications - _____

_____

_____

Physical Stresses

Please list any major physical traumas your child has had (falls, broken bones), along with the approximate date they occurred. _____

_____

_____

_____

_____

_____

Chemical Stresses

Please list any medications your child is currently taking (including panadol)

Past medications

Have you or your child been exposed to any major chemical toxins (amalgam fillings, petrochemicals, agricultural chemicals etc.)

Please provide a brief summary of your childs diet, including chemicals and foods including artificial sweeteners, preservatives, refined and processed foods.

How many cups of water does your child drink a day?

Emotional Stresses

Please list any major emotional issues you may have experienced since birth, along with age of each event. Include changes in lifestyle, home situation, relationship breakups, abuse, violence, traumatic events etc.

Are either parent dealing with large amounts of stress? If so please give details:

List any emotional issues that your child might be dealing with now:

Is there anything else we should know?

Natural Health Works

Informed Consent Form

Patient Information

Chiropractic care is recognised as being an effective and safe method of care for many conditions. Chiropractic adjustments (manipulations) 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, JMPT, 1995. Manga report, Ontario Ministry of Health, 1993)

There are risks associated with all health care procedures which you should be informed about, and changes to the law now require all practitioners who adjust (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 stroke or stroke-like symptoms (approximately 1 in 5.85 million neck manipulations, Haldeman, 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.

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 62,000).[Dvorak study in Principles and Practice of Chiropractic, Haldeman. 2nd Ed.] Please note the may be considerable degree of variation in individual response to chiropractic care.

Consent to Chiropractic Care

The procedures to be used in your case will be described after which you will be asked you have any questions. After speaking with the chiropractor we request that you sign below as your consent to proceed is required.

Patient's signature_____Print name _____
(Parent or Guardian to also sign if patient is under 18)

Chiropractor's signature _____Date_____