

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, name of guardian(s)			
Names & ages of siblings			
Address		Town/City	Postcode
Home Ph	Business Ph	Mobile	
Who referred you to our clinic?		Health Fund	
Major Complaint			
How long has this condition existed?			
Is it getting? <input type="checkbox"/> Worse <input type="checkbox"/> Constant <input type="checkbox"/> Comes/Goes <input type="checkbox"/> Better			
Previous diagnosis/treatment for this condition			
Other complaints			
On any medication?			
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	

During pregnancy did the child's mother

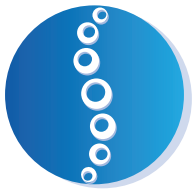
- Have an injury Yes No
- Have good nutrition Yes No
- Exercise Yes No
- Smoke or drink alcohol Yes No
- Take any medication Yes No

As a Baby

- Was child breastfed Yes No
- Was child a headbanger Yes No
- Did child ever fall on head Yes No
- Did child ever fall down stairs Yes No

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
- Hospital Birth Yes No



List date of last

Physical Examination
Blood Test
Chest X-ray
Urine Test

Psychosocial any recent occurrence

Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Death (Family / Friends)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Divorce / Separation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Family Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sleep Disturbances	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Has or does child have problems with

Bowels	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breastfeeding difficulties	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bedwetting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recurrent bladder infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recurrent throat infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recurrent appendicitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Co-ordination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Learning difficulties	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Attention deficit disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sinus	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Restless legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Growing pains	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Colic	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Moodiness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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 Dr. Anthony Kartitopoulos and whomever he may designate as his 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

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that Carnegie Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment to Carnegie Chiropractic at the time of service.

Signature of Parent (or Guardian)

Today's Date