CARNEGIE
CHIROPRACTIC

Age 12 - 17
New Patient Registration Form

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

Who referred you to our clinic? | Health Fund

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?

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

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

List date of last

Physical examination

Blood test

Chest X-ray

Urine test

Name of medical doctor

Location

As a Baby

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

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

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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

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

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