Admin: _____ ☐ SMS ☐ Cliniko ☐ Book ☐ Card ☐ Treatment notes ☐ **CHILD**

Amo
CHIROPRACTIC & FAMILY WELLNESS

PERSONAL DATA

Todays Date:__/__/____

Name _____Age ____DOB ___/___/____

Address _____City _____PostCode_____

Mobile Phone _____

E-mail address_____@_____

Emergency Contact (Name/Number):_____

Parent or Guardian name(if you are under 18) _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Amo Chiropractic can address with your child? _____

_____

Is this an Auto Accident Injury? ❑ Yes ❑ No

Has your child been treated elsewhere? ❑ Yes ❑ No

If **yes**, where? ❑ Emergency Room ❑ Primary Care ❑ Other _____

What services were provided? ❑ MRI ❑X-Rays ❑ Medication ❑ Therapy ❑ Other (details)_____

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received Chiropractic care? ❑Y ❑ N Name of Chiro._____

Who is your Child's Local GP ? Name of GP._____

Has your child consulted any of the following providers? (check all that apply)

❑ Naturopath ❑ Acupuncturist ❑ Homeopath ❑ Massage Therapist

Name of Health Practioners & Reason:_____

The primary system in the body, which coordinates health, is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses your child has been subjected to, how they may relate to their present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatise a baby's spine and cause damage to the spine & nerve system. Please CHECK where and how you were birthed. (If you do not know, please skip to next question)

❑ Home ❑ Natural ❑ Hospital ❑ Caesarian section ❑ Forceps

❑ Breech ❑ Cord around neck ❑ Prolonged labor ❑ Drug induced labor ❑ Suction

HEALTH, WELLNESS AND CHIROPRACTIC CARE

PHYSICAL STRESS:

Please list the major traumas during childhood (injury and date):

_____

Has your child ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? ❑ Y ❑ N

If yes, list body parts injured and dates of injuries: _____

Has your child ever been hospitalized or had surgery? ❑ Y ❑ N If yes, state reason and dates: _____

_____

Does your child currently have any digestive issues? ❑ Y ❑ N If yes, explain:_____

EMOTIONAL STRESS:

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or are, currently, experiencing any of the emotional stresses below:

Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Illness	Y	N	Family	Y	N
Lifestyle change	Y	N	Parents divorce	Y	N			

CHEMICAL STRESS:

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures your child may have had.

Has your child been exposed to any of the following on a regular basis (either in the past or presently)?

❑ Toxic chemicals ❑ Second hand smoke ❑ Drug therapy

❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list:_____

Does your child have allergies or sensitivities to any foods? ❑ Y ❑ N If yes, please list:

_____

Please list all medications (prescribed and over the counter):_____

_____

Note: It is imperative that you list all medications as they may have an influence on your child's care.

WHAT ARE YOUR EXPECTATIONS FROM CHIROPRACTIC CARE?

_____

_____

Payment in full is expected on all services at time of consultation (whether you have insurance coverage or not.)

- Comprehensive Initial Exam: $110 - Regular Visit: $55

Family Visit (3 or more people under the same roof): $45 per person. Extended healing Session (1hour) $ 150

Informed Consent to Chiropractic Care

Changes to the law now require all chiropractors to warn people of material risks, associated with all health care procedures, including Chiropractic.

As in all health care procedures, there are some slight risks with chiropractic care. This includes, but is not limited to:

- Your condition becoming worse;
- Disc injuries, rib fracture, sprains/strains (1 in 139,000 in the neck and 1 in 62,000 in the low back) [1];
- Stroke or stoke like symptoms (1 in 5.85 million neck adjustments) [2] [3].

Put in context, chiropractic has been shown to be 250 times safer than anti-inflammatory drugs [4] and safer than driving a car [5].

Some people may experience some mild soreness for 24 – 48 hours after their adjustments, especially when their body is unwinding. [6] [7] this is a normal sign of change, as may occur after exercise or stretching.

Clinical experience consistently demonstrates ***unexpected improvement*** in people's life. One study indicated that 23% of people experience improvement in some other aspect of their health. [8] Of individuals who experience such improvements:

- 26% experienced improvements in their respiratory system;
- 25% in their digestive system;
- 14% circulatory system/heart;
- 14% eyes/vision.

Broken down into subcategories the benefits were reported as follows:

- Easier to breathe: 21%
- Improved digestive function: 20%
- Clearer/better/sharper vision: 11%

(The references for the information quoted above are provided below.)

Agreement:

I have read and understand the information above. I understand that most care is given in an open setting. A private room is available upon request.
I consent to receive communication from Amo Chiropractic via email, postal mail, text and telephone messaging in connection with my care. If I should withdraw my consent, I will notify the office in writing.

I do not expect the chiropractor to be able to anticipate or explain all the risks and complications. I wish to rely on the chiropractor to exercise his/her judgment during the course of procedures which he/she feels, at the time, based upon the facts known, is in my best interests.

The information I have provided on this case history form is true and accurate to the best of my knowledge. I will have the opportunity to discuss with the chiropractor the nature and purpose of chiropractic adjustments and other procedures as well as other concerns. I understand that results are not guaranteed. I intend this consent form to cover the entire course of my chiropractic care for this and any future presentation.

I give Dr. James Evans D.C. and Dr. Jenna Evans D.C. permission to render care to me today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Signature:(Parent/Guardian if under 18) _____ Print name: _____

Chiropractor signature: _____ Date: _____/_____/_____

(1) Dvorak study in Principles and Practice of Chiropractic, Haldeman, 2nd Ed.
(2) Arterial Dissections Following Cervical Manipulation: The Chiropractic Experience. Haldeman S et al. Canadian Medical Association Journal, Vol 165, No 7, 905-906, 2001.
(3) The Mechanics of Neck Manipulation with Special Consideration of the Vertebral Artery. Herzog W, Symons B. J Can Chiropr Assoc 46(3):134-136, 2002.
(4) A Risk Assessment of Cervical Manipulation vs. NSAID's for the Treatment of Neck Pain. Dabbs V, Lauretti W. J Manipulative Physiol Ther 1995; 18(8):530-6
(5) What are the Risks of Chiropractic Neck Adjustments. Lauretti W. JACA 1999; 36(9):42-47.
(6) Leboeuf-Yde C, Axen I, Ahlefeldt G, Lidefelt P, Rosenbaum A, Thurnherr T. The types of improved nonmusculoskeletal Side effects of chiropractic treatment: a prospective study. Leboeuf-Yde C. J Manipulative Physiol Ther. 1997 Oct;20(8):511-5
(7) Frequency and characteristics of side effects of spinal manipulative therapy. Senstad O et al. Spine. 1997 Feb 15; 22(4):435-40; discussion 440-1.
(8) Symptoms reported after chiropractic spinal manipulative therapy. *J Manipulative Physiol Ther* 1999; 22:559-64

Thank you for choosing Amo Chiropractic.
We look forward to helping you.

Case History – For office use, to be filled in by Doctor.

Chief Complaint:_____
Personal history Relevant to Chief Complaint:_____
_____
_____
Onset:_____
P: Better:_____Worse:_____
Quality:_____
Radiate:_____
Severity: Pain normally is___/10___and at its worst___/10 on the visual analogue scale_____
Timing:_____
Other: _____

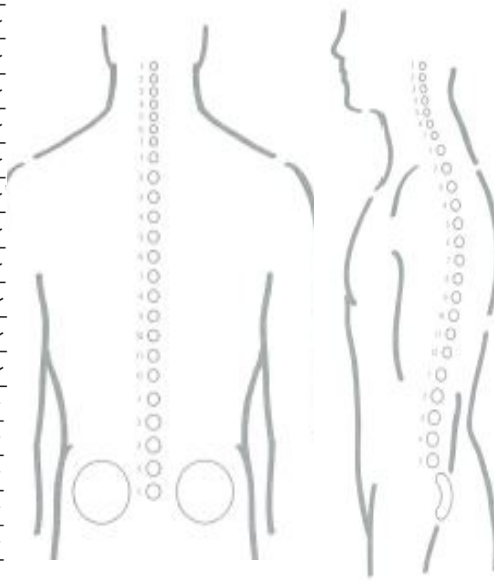
Spinal Analysis

C0 _____
C1 _____
C2 _____
C3 _____
C4 _____
C5 _____
C6 _____
C7 _____
T1 _____
T2 _____
T3 _____
T4 _____
T5 _____
T6 _____
T7 _____
T8 _____
T9 _____
T10_____
T11_____
T12_____
L1 _____
L2 _____
L3 _____
L4 _____
L5 _____
SI Jt_____
Sacrum_____

	Cervical	Pain	Lumbar	Pain
Flex	___(75)		___(90)	
Ext	___(55)		___(30)	
LFlex:L	___(45)		___(30)	
LFlex:R	___(45)		___(30)	
Rot:L	___(80)		___(30)	
Rot:R	___(80)		___(30)	

Posterior View

Left Profile



Unsettled Baby.		
Subluxation	Occiput, Atlas, Shoulder, Sacrum, Cranium	/10
Extreme/Illness	Vomiting, Poo, Bloating,	/10
Toxins/Sensitivities	Wheat, Dairy, Formula	/10
Tired	Enough Sleep	/10
Love/Nurture	Needing love	/10
Energy/Food	Finishing bottle, Wanting More	/10

Ortho/Neuro
Leg Length: Df: R / L - / +
Rhomberg: - / +
DTR:
Abnormal Reflexes:

Comments:
_____
_____
_____
_____