

Paediatric New Patient Information Form



Child's full name: _____

DOB: ____/____/____

Address: _____

Post code: _____

Private Health Fund: *(if applicable)* _____

GP Name & Location:

I consent to Casey Central Osteopathy notifying my child's GP that they are having Osteopathic treatment *(if required)*.

Guardian Details

Name: _____

Relationship to above mentioned child: _____

Address: _____

Post code: _____

as above address

Home Phone: (____) _____ Mobile: _____

Work: (____) _____

Email: _____

Emergency contact name & number: _____ (____) _____

How did you hear about Casey Central Osteopathy?

Paediatric Medical History

Mother's age at time of birth: _____

Pregnancy #? _____

Date of birth: ____/____/_____

Was this date Early _____ Late _____ On time

How long was labour? _____

Was this birth: Natural birth or C-section

Was mother induced? YES or NO

Was there any assistance required in the birthing process? NO Vacuum Forceps

Any previous miscarriages? YES or NO

Were any pain killers required? Gas Epidural Pethidine Other _____

How did your child present at birth? Anterior Posterior Breech Other _____

What problems, if any did mother have with this pregnancy/childbirth? _____

Child's birth weight: _____ Child's birth length: _____ Child's head circumference: _____

How is your child feeding: Breast milk, if so how long for now? _____ Formula in bottle Both N/A

Are your child's vaccinations up to date: YES or NO

Has your child ever suffered from the following?

Reflux/Vomiting	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Constipation/Diarrhoea	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Sleeping problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Problems latching/sucking	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Feeding/Diet problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Colic	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Problems with wind	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Motor vehicle accident	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Headaches	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Fracture	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Nausea	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Joint dysplasia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hearing problems/tinnitus	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Ear/Throat Infections	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Vision problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Breathing problems/Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Difficulty with speech	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Bowel/bladder problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Surgery	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Dental problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Trauma/Falls	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Knocks to head/concussion	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Bleeding disorder	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Epilepsy/Seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Liver disease/Jaundice	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO



Childhood development and behaviour – Please indicate if & when your child developed these milestones

- | | |
|--|---|
| <input type="checkbox"/> Grip motion _____ | <input type="checkbox"/> Standing with assistance _____ |
| <input type="checkbox"/> Rolling _____ | <input type="checkbox"/> Standing by oneself _____ |
| <input type="checkbox"/> Tummy time _____ | <input type="checkbox"/> Crawling _____ |
| <input type="checkbox"/> Sitting _____ | <input type="checkbox"/> Talking _____ |
| <input type="checkbox"/> Walking _____ | <input type="checkbox"/> Toilet trained _____ |



Main presenting complaint:

What is the main purpose of your child's visit today? _____

When did the problem start? _____

When does the problem generally occur? _____

Is the problem worse: Morning Afternoon Evening Middle of the night No pattern

What do you think aggravates the problem? _____

What do you think relieves the problem? _____

Have there been any investigations or tests performed for this particular problem?

- Xrays Bloods Ultrasound Scans Other _____

Have you tried other treatment options or seen any other Health Professionals for this problem?

- Osteo Chiro Physio GP/Pediatrician Midwife Sleep school Other _____

Please list any medications or supplements your child is currently on;

Pediatric Osteopathic informed consent

Osteopathy is a recognised manual therapy for the care of many musculoskeletal related conditions. However, much like anything you – *the guardian* must recognise that there are slight risks associated with all health care procedures or treatments. This includes Osteopathic Manual Techniques, which you must be informed about. All of our Practitioners are registered with the Australian Health Practitioner Regulation Agency (APHRA). Our philosophy is to look at the body as ONE WHOLE UNIT to find the primary source of an individual's problem. Our Osteopathic Practitioners will aim to help you understand what your child's body is going through so that you will leave with a better knowledge about limitations and how to prevent and manage your child's problem down the track.

Normal treatment effects:

The initial 24-48 hours after an Osteopathic treatment your child may experience mild temporary post-treatment soreness which may represent as;

- Irritability
- Discomfort
- Loss of appetite
- Trouble sleeping

There may also be temporary exacerbation of your child's symptoms or underlying condition. Please be advised that this is considered to be normal, as your child's body is responding to the treatment.

I – the guardian have had the opportunity to discuss the proposed care with the Practitioner below. I have disclosed all relevant health and medical information regarding my child. I also acknowledge that I have had the opportunity to question the nature, extent and purpose of care of my child's Osteopathic treatment. I understand that I can withdraw consent to treatment at any time.

Our Privacy Statement sets out the policy of Casey Central Osteopathy with respect to the way in which we collect, use, disclose, store, secure and dispose of Personal Information about our patients. The information that we collect from you allows our Practitioner/s to assess your health and provide you with the utmost care possible. The information will ONLY be used for these purposes in strict adherence to the National Privacy Principles of the State and National Government's privacy legislation. I

Would you like to opt in to: SMS reminders Appointment emails Newsletter emails

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I confirm that I have read and understood ALL the information above; I hereby acknowledge my consent to the above and for my child to the proposed Osteopathic care by the treating practitioner below.

Patient name: _____

Guardian name: _____

Guardian signature: _____

Osteopaths name: _____

Osteopaths signature: _____

Dated: ____/____/____