PERSONAL DETAILS – Please print clearly

Surname:_____ Title:_____ Age_____

Forename(s):_____ Date of Birth:_____

Name of Parents:_____

Full Address:_____

_____ Postcode:_____

Home Phone No:_____ Mobile: _____

Email:_____

Referred by:_____ Newspaper/Mag □ Web □ Phonebook □

HEALTH DETAILS

Weight:_____ Height/Length:_____

Name of GP:_____ Telephone:_____

Surgery Name/Address:_____

Prescribed medications currently taking:_____

Non-prescribed medications:_____

PRENATAL

Mother's health status before pregnancy:_____

Mother's health status during pregnancy:_____

Mother's age at birth:_____

Any prior miscarriages:_____ How many:_____ How long ago:_____

Any drugs (prescription or otherwise) used before or during the pregnancy (including smoking or alcohol):_____

How much weight was gained during pregnancy:_____

What term was the child at birth? Full term / Premature _____

NATAL

Duration and extent of labor and delivery:_____

Did the mother require any analgesic drug? Yes / No_____

Spontaneous or induced labor:_____

Caesarean delivery? Yes / No

Natural delivery? Yes / No Devices used: Forceps / Vacuum extract / Other

Presentation / Position of the child at birth:_____

NEONATAL

Apgar score directly after delivery:_____

Problems with Feeding / Respiration / Cyanosis / Jaundice / Anaemia / Convulsions /

Congenital anomalies / Infection / Other

Details:_____

FEEDING / NUTRITIONAL HISTORY

Was the child Breastfed / Breastfed and Supplementary / Solely Supplemented

Any problems associated with feeding:_____

Age at which solids were introduced:_____

Any allergic reactions? Yes / No

If yes, what occurred:_____

What are the child's current eating habits:_____

_____

CHILDHOOD ILLNESSES AND EXPOSURES

Chickenpox_____ Whooping cough_____

Mumps_____ Measles_____

Asthma_____ Rubella_____

Headaches_____ Chronic colds / flu_____

Chronic earaches / infections_____

OPERATIONS / INJURIES / HOSPITALISATIONS_____

_____

_____

ALLERGIES_____

_____

VACCINATIONS

Which vaccinations has your child had and at what age with each vaccine:_____

_____

_____

Are there any vaccines they are scheduled to have:_____

_____

Has any member of the family suffered from the following:

Tick if applicable

	Mother	Father	Family member
Liver / Kidney problem	□	□	□
Stroke / Heart problem	□	□	□
Blood pressure problem	□	□	□
Lung / Breathing problems	□	□	□
Digestion problem	□	□	□
Bowel problem	□	□	□
Bladder problem	□	□	□
Reproductive problem	□	□	□
Circulation problem	□	□	□
Diabetes	□	□	□
Cancer	□	□	□
Epilepsy / Nerve disorder	□	□	□
Allergy and/or skin disorder	□	□	□
Migraine / Headaches	□	□	□
Dizziness	□	□	□
Tinnitus	□	□	□
Ear / nose / throat problem	□	□	□
Athritis / orthopaedic problem	□	□	□
Multiple sclerosis	□	□	□
Psychological problem	□	□	□
Psychiatric / mental problem	□	□	□

Any other problem_____

Please describe the problem that has brought you to the office today:_____

_____

_____

_____

_____

What treatment(s) have been given for the problem above:_____

_____

_____

_____

INFORMED CONSENT

PLEASE READ and ASK ANY QUESTIONS BEFORE SIGNING

Name: _____

Parent/Guardian: _____

Consent to Physical Examination

I understand that I shall need to answer necessary questions and undergo examination procedures sufficient to determine my suitability for any care the Clinic might recommend. I consent to the Clinic having access to information contained in my medical records and to providing these on request to appropriate third parties who are legally entitled to such information. I consent to an appropriate physical examination.

Consent to Treatment

I understand that I shall be responsible for all associated costs incurred on usual, or specially agreed, terms. I consent to treatment as outlined to me in pursuit of my primary complaint and to areas associated with it.

Signed (Parent/Guardian): _____ Date: _____

Data Protection Policy

Under the Data Protection (1998) Act, this Clinic is required to retain information pertaining to consultation and treatments for a period of 7 years. The confidentiality of all information and records will be strictly observed and will only be released to third parties who are legally entitled according to the Act. All records will be kept securely, either electronically or on paper, for the 7 year period, after which time they will be destroyed.

I acknowledge that I understand this Policy and agree to it

Signed (Parent/Guardian): _____ Date: _____