NEW CHILD PATIENT FORM Date: __/__/___

SYMMETRY CHIROPRACTIC

Your Contact Details

Child's name: _____
Parent's name(s): _____
Date of Birth: __/__/____ How old today? _____
Address:_____
_____
Postcode:_____
Home Tel No: _____
Work Tel No: _____
Mobile Tel No:_____
Email Address: _____ Can we email you? YES / NO
How do you prefer to be contacted? (Please circle) SMS / Call mobile/ Call home / Email me

Your GP & Practice name: _____

How did you hear about us? Please tell us the name of the person if you can, so we can say "thank you." _____

Past Medical History:

Ever had a road traffic accident?	YES / NO	Undergone any surgery?	YES / NO
Other injuries/ traumas?	YES / NO	Any allergies?	YES / NO
Been in hospital for illness or tests?	YES / NO	Broken any bones?	YES / NO

Any family history of medical problems? YES / NO
Do they take any medication/supplements? YES / NO
Do they have any medical conditions (including those they were born with)? YES / NO

Prenatal/Birth

Any maternal illness or medical treatment during pregnancy?

_____

Did you child follow their milestones?:

7-9 months – sitting unaided	YES/NO	9-12 months – standing unsupported	YES/NO
Did they bum-shuffle?	YES/NO		
11 months: crawling	YES/NO	14 months: walks unaided	YES/NO
2 years: speech	YES/NO	3 years – self dressing	YES/NO

Their Lifestyle

Do they drink water regularly?	YES / NO	How many cups/day?	_____
Are they active?	YES / NO	How? _____	
Do they sleep well?		YES / NO	
Do they have regular bowel movements?		YES / NO	
Do they have a good diet?		YES / NO	
Do they have good emotional/mental health?		YES / NO	Why? _____

Why you are here today

Current problems/ reasons for consulting our office (please list the most severe first):

1. _____
   How long? _____
2. _____
   How long? _____
3. _____
   How long? _____

Other problems: Is or has your child ever experienced?

Constipation Diarrhoea Hyperactivity Attention issues Diagnosed with ADHD
Concentration issues Learning Difficulties Behavioural problems
Balance or coordination issues Diagnosed with Autistic Spectrum Disorder
Recurrent colds Ear Aches Asthma Scoliosis Growing Pains Headaches Back pain
Neck pain Sinus problems Bedwetting
Night terrors Joint problems Clicky hip Convulsions Tonsillitis
Chronic fatigue Food intolerances Food dislikes/issues with foods

Do you have other children? If so, please give number and ages:

_____

Over the last 3 months have they experienced:

Any change in bowel/bladder function?	YES / NO	Loss of appetite?	YES / NO
Noticeable change in weight?	YES / NO	Pain at night?	YES / NO

SYMMETRY CHIROPRACTIC

Informed Consent to Chiropractic Care

I hereby give my consent to physical examination for my child by the Chiropractor.
I have been given a full explanation regarding my child's condition.
I have had the opportunity to ask questions and been advised of all treatment options available. I have been advised of possible side effects associated with treatment. I consent to chiropractic treatment for my child as outlined to me.
If you desire a medical diagnosis or believe that you may require medical attention you are advised to consult with your GP in addition to the chiropractor, even while chiropractic care continues. The effectiveness of chiropractic care varies between patients and you are free to stop care at any time or seek advice elsewhere. Your child will be regularly re-assessed throughout their treatment programme to ensure that chiropractic care continues to be appropriate for them.

Healthcare Insurance

Insurance policies are an agreement between the insured person and insurer. I understand that all services rendered to me by Symmetry Chiropractic are charged directly to me and that I am personally responsible for making payment on or before the delivery of services.

Non-attendance without notice

I understand that should I fail to attend a scheduled appointment without prior notice of 24h or as reasonably as possible, that I will be charged for the missed appointment.

Your Data

We are fully compliant with the General Data Protection Regulations and therefore will only process your information in a lawful and transparent manner. This means we will only gather information from you that we need and it will always be available to you free of charge; this information will always be securely stored; this information will always be up to date and we will ask you on a regular basis to update us; we only keep this information for the length of time required by the General Chiropractic Council (8 years) after which your data will be securely deleted and destroyed. [In the case of children, we have to keep their files for a period of 8 years after their 18th birthday]. We will never share your information without your consent.
If you require access to the records we hold about you from 25th May 2018, all you need to do is write to the clinic with your request or email your request to info@symmetrychiropractic.co.uk and ensure that your request is signed and dated. We also need to verify your identity but will phone you to confirm the request prior to the release of any personal information.
Copies of our full Data Protection Policy are available on request and are also on our website symmetrychiropractic.co.uk.

Please sign that you have received sufficient information to consent to begin chiropractic care and consent to be adjusted by any qualified chiropractor at Symmetry Chiropractic.

Patient name (block capitals) _____

Signature of Patient or Legal Guardian _____

Date _____