WELCOME TO THE BUSSELTON OSTEOPATHIC CLINIC

The information completed on this form is strictly confidential.

No release of information will be given without prior permission of the parent/guardian.

CHILD (0-13 YRS) PATIENT INFORMATION

Surname: ______________________________ First name: _____________________________

Address: ____Postcode:_____

Date of Birth: _________________________ Place of birth: ____________________Sex: F/M

Parents/Guardians: ____

Siblings: ____ Pets: ___________________

Tel: Home: __________________ Work: __________________Mobile: ___________________

Email address: ____

GP: ____ Tel: ___________________________

How did you hear about this clinic? ____

Is the injury, pain or illness related to a motor vehicle accident? _______________________

If 'yes' then is it covered by M.V.I.T.? ____

If you have a claim number for this injury, please write it here: ________________________

I understand there is a fee for missed appointments. Payment is due when the service is performed and can be made by cash, cheque, credit card or EFTPOS.

Signature: ____ Date: ___________________

Child's presenting symptoms: ____

Child's general Health: ____

Your pregnancy: Maternal age: ___

Amniocentesis: Y N

CVS: Chorionic Villus sampling (Down syndrome, cystic fibrosis) Y N

AFT: Alpha-Fetoprotein (Chromosomal abnormalities/spina bifida) Y N

Head engaged when? ____wks

Did you take any medication during your pregnancy? Y N

Child's birth: Birth weight:_____ Gestation: _____

Spontaneous: Y N	Analgesics:		First Breath:		
Amniotomy: Y N	G & A	Y N	First cry:		
(rupture of foetal membrane)	TENS:	Y N	First suck:		
Induced Y N	Pethidine:	Y N	Episiotomy	Y N	
First stage (hrs):	Epidural:	Y N	Forceps:	Y N	
	Other:	Y N	Ventouse:	Y N	APGAR (Imin):
			Caesarean:	Y N	APGAR (5min):

First week post partum: Moulding: Y N

General health, feeding, sleeping etc: ________________ Bruising: Y N

Developmental milestones: ____

Child's medical history:

Illnesses:

Accidents:

Operations:

Vaccinations:

Allergies:

Child's current medications/treatment: ____

Family history:

Smoking in the child's environment? Y N

Do you drive a Hybrid Car? Y N

Do you use a Wireless Baby Monitor? Y N

Do you use a mobile phone whilst nursing your baby? Y N

(The last three questions refer to the effects from the electromagnetic field emanating from the car/monitor/mobile phones etc. that are likely to cause some disturbance of the central nervous system of your baby/child.)

Thank you for completing this form.

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INFORMED CONSENT TO OSTEOPATHIC CARE

When performed by a qualified Osteopath, spinal manipulation is an effective and safe method of treatment for many painful conditions. There are however, risks associated with any treatment and I am required to inform you of these, even though there has never been a case in this clinic. Please read the following carefully and write down any questions you may have.

I hereby request and consent to the performance of Osteopathic treatment on me by Dr Yvan Ducat, Dr Kamisha Cleaver and/or any other Osteopath working in this clinic authorised by Dr Yvan Ducat.

I have had the opportunity to discuss the nature and purpose of Osteopathic treatment with the Osteopath.

I understand that results are not guaranteed.

I understand and am informed, that as in the practice of medicine, in the practice of Osteopathy there are some very slight risks to treatment, including but not limited to, muscle and joint soreness, muscle strains, joint sprains, fractures, disc injuries, strokes and stroke like episodes.

I do not expect the Osteopath to be able to anticipate and explain all risks and complications and I wish to rely on the Osteopath to exercise judgement during the course of treatment, which the Osteopath feels at the time, based upon the facts then known, and is in my best interests.

I have read the above and I have also had the opportunity to ask questions about its content.

I intend this consent form to cover the entire course of treatment for my present condition, and for other future condition(s) for which I seek treatment. I understand that I can withdraw my consent at any time.

Dr Yvan Ducat
D.O. (Osteopath)

Dr Kamisha Cleaver
BaClinSciM.Ost (Osteopath)

____
Patient's name:

____
Patient's signature:

____
Date: