



For children 13 to 16 years of age

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Your GP's name & address:

Parent/Guardian's Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (H) \_\_\_\_\_

(B) \_\_\_\_\_

(M) \_\_\_\_\_

Email: \_\_\_\_\_

D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_

Last visit: \_\_\_\_\_

Permission to discuss your child's care and treatment with your GP/other health care providers?

Yes No Initials \_\_\_\_\_

Reason for today's visit:

How did you hear about Canberra City Osteopathy? (Please circle)

GP (Please provide name) \_\_\_\_\_

Collaegue (Please provide name) \_\_\_\_\_

Pilates

Friend (Please provide name) \_\_\_\_\_

Google

Internet

Family (Please provide name) \_\_\_\_\_

Yellow Pages

Natural Therapy Pages

Local/Walked Past

Maternal Health Nurse

Local Gym

Other \_\_\_\_\_

For patient's under 16 years of age, the signature off a parent/guardian is required:

I give consent for \_\_\_\_\_ to receive Osteopathic treatment.

Name of parent/guardian: \_\_\_\_\_ Signature: \_\_\_\_\_

Child's Health & Lifestyle

Has any other treatment been sought for this complaint?

Yes / No \_\_\_\_\_

Have there been any tests/scans/x-rays for this complaint?

Does the child have any medical conditions? Yes / No

(Please list if yes) \_\_\_\_\_

Please list current medications including vitamins/supplements and anti-inflammatory medications: \_\_\_\_\_

Has the child been hospitalised or had any surgery or

traumas (including broken bones & sprains) or car accidents? If so, please give details including dates

Does the child have any medical implants or prosthesis?

(pacemaker, metal pins, etc) \_\_\_\_\_

Does the child exercise? Yes / No

What type and how much?

Does the child have any allergies? Please give details.

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Is the child a vegan or vegetarian? Yes / No

Does the child have regular sleeping patterns? Yes / No

Does the child show any behavioural problems? Yes / No

Has the child had any dental work done? Yes / No

Has the child recently had a growth spurt? Yes /No

Do you smoke or drink alcohol? Yes / No

If yes, How much? \_\_\_\_\_

Girls: Age at first period \_\_\_\_\_

Are they painful? Yes / No

Do you take the pill? Yes / No

Boys: Age at voice breaking \_\_\_\_\_

**In the past 6 weeks, has the child experienced: (please circle)**

Chest pain

Shortness of breath/Trouble breathing

Cough/Wheeze

Heart palpitations/irregular pulse

Weight loss or weight gain

Increased thirst

Blood or mucus in the stool

Fatigue /Tiring easily

Headaches

Dizziness

Fainting

Breath holding

Fevers or Chills

Change in bowel habits

Change in bladder habits (including bed wetting)

Abdominal pain

ringing in the Ears or deafness

Changes in Vision

Joint Pain or Swelling or Stiffness

Heartburn or Indigestion

**Family History:**

Please circle any family history of the following (and who had the condition):

Cancer

Liver disease/Hepatitis

Diabetes

Heart disease

Epilepsy/Seizures

Thyroid disease

Circulation problems

Incontinence

Kidney disease

Asthma

Urinary infections

HIV/AIDS

Migraine

Arthritis

Mental Disorder (including depression)

Any other Significant family history?

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