



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**

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.

\_\_\_\_\_

\_\_\_\_\_

How old was the child when they began: (if applicable)  
 Crawling \_\_\_\_\_ Walking \_\_\_\_\_ Toilet Training \_\_\_\_\_

Is there any history of bedwetting? Yes / No

Is the child receiving immunizations? Yes / No

If yes, Any reactions? \_\_\_\_\_

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

Girls: Age at first period \_\_\_\_\_  
 Are they painful? Yes / No

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

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

- |                                       |  |
|---------------------------------------|--|
| Chest pain                            | Fainting   |
| Shortness of breath/Trouble breathing | Breath holding                                   |
| Cough/Wheeze                          | Fevers or Chills                                 |
| Heart palpitations/irregular pulse    | Change in bowel habits                           |
| Weight loss or weight gain            | Change in bladder habits (including bed wetting) |
| Increased thirst                      | Abdominal pain                                   |
| Blood or mucus in the stool           | ringing in the Ears or deafness                  |
| Fatigue /Tiring easily                | Changes in Vision                                |
| Headaches                             | Joint Pain or Swelling or Stiffness              |
| Dizziness                             | 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?

\_\_\_\_\_

\_\_\_\_\_