canberra city
HEALTH NETWORK
London Circuit | Casey Market Town

Initial Consultation Form

For children 13 to 17 years

Today's Date: _____

Child's Full Name: _____

Parent/Guardian Name:_____

Address:_____

_____

_____

Phone: (H) _____

(B) _____**(M)**_____

Email:

_____

D.O.B: _____ **Age:** _____

Emergency Contact Details of Parent/Guardian:

Name: _____

Relationship: _____

Best Contact Number: _____

Your GP's name, address and phone number

_____

_____

_____

Last visit:_____

Permission to discuss the child's care and treatment with your GP/other health care providers?
Yes No **Please sign** _____

Cancellations: *It is important that we receive* ***4 hours' notice**** *for any cancellation or any changes made to appointments so that we can give others an opportunity to take that appointment.* ****24 hrs notice is required for Psychology appointments****.*

If you fail to attend an appointment or are unable to give sufficient notice, a cancellation fee will apply.

Please Sign _____

Child's Health:
Reason for today's visit:

_____

_____

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

Yes No *(details)* _____

- Has any other treatment been sought for this complaint?

Yes No (*please specify*) _____

- Has the child previously had any form of manual therapy?
Yes No If so, which modality and did the child have any adverse reactions?

_____

_____

- Does the child have any medical conditions?

Yes No (details):_____

_____

- 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? **Yes No**
If so, please give details including dates:

_____

_____

- Does the child have any medical implants or prosthesis? (pacemaker, metal pins, etc.) **Yes No**
*(details):*_____

_____

- Does the child exercise? **Yes No**

What type/How often?

_____

_____

- Does the child have any allergies? **Yes No**

Details:_____

_____

Is the child a vegan or vegetarian? Yes / No

Does the child have regular sleeping patterns? **Yes No**

Does the child display any behavioural problems? **Yes No**

If yes, details_____

_____

Please ensure both sides of this form have been completed and then promptly return to reception before your consultation

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

Details: _____

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

Does the child 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 _____

Any other comments about the child's health?_____

_____

Family History:

Have you or anyone in your family ever suffered from:
(Please circle and who had the condition)

Cancer	Heart disease
Circulation problems	Asthma
Migraine	Liver disease/Hepatitis
Epilepsy/Seizures	Incontinence
Urinary infections	Arthritis
Diabetes	Thyroid disease
Kidney disease	HIV/AIDS

Mental health issues *(including depression)*

Any other ***significant*** family history? *(please list)*

_____

_____

Pain and other physical conditions often affect (and are influenced by) how we feel, think and act. So that we can provide the child with the best possible treatment, please let us know if they have been experiencing any of the following *(please tick all that apply)*:

__ Difficulty falling or staying asleep
__ Reduced motivation
__ Feeling down, irritable or depressed
__ Feeling tense, fearful or anxious
__ Changes in appetite
__ Trouble with concentration and/or memory
__ Less desire to spend time with others
__ Stress or conflict in important relationships

In the past 6 weeks, has the child experienced any unusual or persistent: *(please circle yes or no)*

Chest pain	**Yes**	**No**
Shortness of breath/Trouble breathing	**Yes**	**No**
Cough/Wheeze	**Yes**	**No**
Heart palpitations/irregular pulse	**Yes**	**No**
Weight loss or weight gain	**Yes**	**No**
Increased thirst	**Yes**	**No**
Blood or mucus in the stool	**Yes**	**No**
Fatigue / Tiring easily	**Yes**	**No**
Headaches	**Yes**	**No**
Dizziness	**Yes**	**No**
Fainting	**Yes**	**No**
Breath holding	**Yes**	**No**
Fevers or Chills	**Yes**	**No**
Change in bowel habits	**Yes**	**No**
Change in bladder habits (including bed wetting)	**Yes**	**No**
Abdominal pain	**Yes**	**No**
Ringing in the Ears or deafness	**Yes**	**No**
Changes in Vision	**Yes**	**No**
Joint Pain or Swelling or Stiffness	**Yes**	**No**
Heartburn or Indigestion	**Yes**	**No**

Other:

_____

How did you hear about Canberra City Health Network? *(please circle and provide details)*

GP / Friend / Family / Colleague / Pilates / Yoga

*(name)*_____

Website

Yellow Pages Online	Yowani Country Club	City News
Local/Walked past	Natural Therapy Pages	A-Frame

Other (please specify):_____

_____

Google Search *(what did you search?)*

_____

_____

For patients under 18 years of age, the signature of a parent/guardian is required:

I give consent for (*child's name*)_____ to receive treatment at Canberra City Health Network.

Name of parent/guardian: _____Signature:_____