

# Your Child's Unique Story



- Natural
- Health
- Care
- Professionals

DATE: / /

FIRST NAME: \_\_\_\_\_ SURNAME: \_\_\_\_\_

PREFERRED NAME: \_\_\_\_\_ SEX: Female / Male

CHILD'S ADDRESS: \_\_\_\_\_

CHILD'S HOME PHONE: \_\_\_\_\_ D.O.B: / / AGE: \_\_\_\_\_

## FAMILY INFORMATION

Mother's name: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (M) \_\_\_\_\_

Email address: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Father's name: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (M) \_\_\_\_\_

Email address: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Other contact name: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (M) \_\_\_\_\_

Email address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Siblings' names and ages: \_\_\_\_\_

## CHILD'S HEALTH CONTACTS GP/BIRTHING HELPER/PAEDIATRICIAN/OTHER

Name: \_\_\_\_\_ Phone: (W) \_\_\_\_\_ (M) \_\_\_\_\_

Email address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (W) \_\_\_\_\_ (M) \_\_\_\_\_

Email address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (W) \_\_\_\_\_ (M) \_\_\_\_\_

Email address: \_\_\_\_\_ Relationship: \_\_\_\_\_

REFERRED BY: (If someone had recommended you to us, please let us know as we would like to thank them)

PATIENT NAME: \_\_\_\_\_

YELLOW PAGES

FAMILY NAME: \_\_\_\_\_

STREET SIGN

FRIEND NAME: \_\_\_\_\_

OTHER



Welcome to family care @ hands on, we focus on your health as an individual from 0 to 99 years of age!  
Your essential growth and development occurs from conception through early childhood years.

Please indicate the areas you would like assistance with (i.e. growth problems/walking and crawling issues/ reflex release assessment/irritability/tantrums/natural health diet/supplements/homeopathics/ birth trauma/ poor general development/poor learning skills/poor co-ordination/poor reading and writing integration/health disorder/illness/other):

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### **PREGNANCY/BIRTH/EARLY CHILDHOOD HISTORY**

Term of pregnancy (weeks) \_\_\_\_\_ Was the birth artificially started? Y/N If yes, how \_\_\_\_\_  
How long was 1<sup>st</sup> stage \_\_\_\_\_ 2<sup>nd</sup> stage \_\_\_\_\_ Presentation (head/face /breech) \_\_\_\_\_  
Birth Weight \_\_\_\_\_ kg Height \_\_\_\_\_ cm Apgar: Initially= \_\_\_\_/10, at 5 min \_\_\_\_/10

Birth location (hospital/home/birth centre/delivery ward): \_\_\_\_\_

Birth arrival type (vaginal/elective caesarean/induced/forceps/vacuum /emergency/other): \_\_\_\_\_

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Birth happenings (drugs during labour/ foetal monitoring/distress/meconium staining/intensive care/ hospital admission/damage to mother and or baby/vaccinations at birth/complications): \_\_\_\_\_

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Sleep habits (baby goes to sleep easily/how long/has a preferred daily sleeping pattern/uses dummy to soothe): \_\_\_\_\_

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Early feeding habits (breast bottle feeding/feeds regularly or on demand/feeding difficulties/cries a lot/intestinal gas/pulls legs up/food allergies or sensitivities/one breast preference/how long breast fed/ when was solid food introduced/food and drink preferences): \_\_\_\_\_

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Early patterns (irritable when nappy or clothes changed/arches body, head, neck frequently/lots of fevers/unsettled after vaccinations/unusual lethargy/sensitivities/skin rashes/asthma/other): \_\_\_\_\_

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**EARLY CHILDHOOD TRAUMA HISTORY**

(Falls/sibling associated accidents/emotional changes/medications/other/motor vehicle accidents/surgeries /broken bones/vaccinations/social issues): \_\_\_\_\_

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**MEDICATION/SUPPLEMENTATION:**

Please detail any medication including dosage (e.g. prescribed drugs, aspirin, antibiotics, panadol etc...):

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Please detail any supplements including dosage (e.g. vitamins, minerals, essential fatty acids etc...):

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Please detail any vaccinations including date/age of child:

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**MUM’S PRECONCEPTION, PREGNANCY AND BIRTH HISTORY SUMMARY**

The following questions should prompt you for details and help us to help you get results. Please answer yes/no if mum experienced any of the following during each phase listed below.

DURING/WHILE:	PRECONCEPTION	PREGNANCY	BREAST FEEDING	OTHER COMMENTS
Falls/injuries/accidents				
Hospitalisations/surgeries				
Medications				
Diabetes				
High blood pressure				
Anaemia				
Morning sickness				
Back/pelvic problems				

DURING/WHILE:	PRECONCEPTION	PREGNANCY	BREAST FEEDING	OTHER COMMENTS
Abnormal bleeding				
Regular exercise				
Balanced diet				
Nutritional supplements				
Alcohol				
Tobacco				
Stress				
Worked				

PLEASE NOTE: Hands on requires immediate payment each time of consultation.  
 Cash, Cheque, EFTPOS, Mastercard, Visa, Diners and American Express are accepted.  
 Credit card account facility is well patronised for minors treatment (visits without parent) and recommended for the busy individual to minimise waiting time during visits to the practice.

I understand that no accounts are rendered and my payments will be:

Cash                       Cheque                       Credit

- I understand that this practice is thorough and requires a comprehensive examination including xrays; to give you the best possible care by assessing all information. Your examination results will be explained over two reports. Your initial critical phase that follows involves from 3 to 12 weeks of regular adjustments. Regular progress examinations ensure we are aware of your health needs. You are required to be enabled to help yourself with 2 to 3 educational appointments that will show you how to help yourself along the way back to full health and vitality.
- I understand that as a multiple location practice that my information will be stored on a central server and transferred via a secure internet connection to each of the practices if and when necessary.
- I understand that this practice does not use any rotary manipulation (rotary manipulation is practiced in chiropractic generally). *hands on does not administer any rotation to the neck or spine.* It is also to be noted that any therapy determined to have benefit to the body will inherently involve risks associated with any healthcare intervention. Please duly note this and enquire if you require more understanding of this area of health practice.
- I understand that this practice requires at least 24 hour notice for cancellations and that if you cancel on the day or fail to show up a missed appointment fee will be charged. This is out of consideration for others who may be waiting for an appointment. Your cooperation is appreciated.

In an emergency please contact:

NAME: \_\_\_\_\_ CONTACT: \_\_\_\_\_

**Please sign on completion:**

DECLARATION FOR A MINOR: I, \_\_\_\_\_ being parent/guardian of \_\_\_\_\_  
 \_\_\_\_\_ hereby consent to my child receiving care at hands on.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(Relationship e.g. parent/separated/divorced)