west perth osteopathy
whole body health
(08) 9485 2800

Paediatric Patient Information – 0-2 years **Date:** ____________________

We appreciate your patience in fully completing this confidential questionnaire. Your information will be kept strictly private according to clinic policy. The information is necessary in assisting us to provide the best care and will not be divulged to any other person without your prior consent.

Child's Name: ______________________________ D.O. B. ____________________

Parents' Names: ______________________________ Siblings: ______________________________

Parents' Email: ____

Address:____

Parents' Contact Number/s: (H/M): ______________________________(W) ______________________________

G.P. &/or Paediatrician's Name & Location: ____

Private Health Fund: ____

Is your child taking any medications/natural supplements? □ Y □ N If yes, please specify: __________________

____

How did you find out about West Perth Osteopathy?

□ Friend/Relative. Please specify____

□ Yellow Pages Printed □ Yellow Pages On-Line □ Our Website □ Google

□ Natural Therapy Pages □ Signage □ Australian Osteopathic Association (AOA)

□ Professional (e.g. GP, Podiatrist), Please specify____

PATIENT HEALTH INFORMATION

What is your reason for attending the clinic?____

____

Have you seen any other health care practitioners for these problems? □Y □N

If so, whom?____________________________. When was your child last seen & what were the results of treatment?

____

Is your child under the care of any other health care practitioners?______________________________

____

Natural or Assisted Conception (e.g. IVF)? ____

Length of pregnancy: ____

Please circle all that apply:

Hospital Birth Home Birth Vaginal Delivery Caesarean Epidural Induction

Forceps Vacuum Breech Position Jaundice Meconium Antibiotics (Mother/Baby)

Total length of labour: ____

Length of pushing phase: ____

APGAR score: ____

Strength of First Cry: ______________________

Birth Weight: ______________________ Current Weight: ______________________

Did the patient get stuck in the birth canal? ____________. If yes, please explain: ____________

____

Did the patient have any bruising after birth? ____________. If yes, please explain: ____________

____

Please explain any other events/complications during pregnancy or birth: ____________

____

Describe the patient's health in the first month: ______________________

____

Child's Health History	*Y*	*N*	*Please explain, if ticked Y*
Coughing / Wheezing			
Frequent Infections			
Ear Infections			
Colic			
Reflux / Vomiting			
Constipation / Diarrhoea			
Heart Murmur			
Anaemia			
Eczema			
Thrush			
Epilepsy / Seizures			
Other			

MOTHER'S ANTENATAL & POSTNATAL MEDICAL HISTORY

Mother's Antenatal Health	*Y*	*N*	*Please explain, if ticked Y*
Nausea			
Gestational Diabetes			
Depression			
Physical / Emotional Trauma			
Bleeding			
Over the Counter Medicines			
Prescription Medicines			
Supplements			
Illness			

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Stress			
Exercise			
Alcohol Consumption			
Smoking			
Recreational Drugs			
Other			

Mother's Postnatal Health (e.g. postnatal depression, etc.): ____________________________

____

PATIENT'S DEVELOPMENTAL HISTORY

At what age did the patient first:

Smile: ______________________ Crawl: ______________________

Hold Head: ______________________ Walk: ______________________

Roll: ______________________ Talk: ______________________

Sit: ______________________ Toilet Train: ______________________

DIETARY INFORMATION

Was the patient breastfed? ____________. If yes, for how long? ______________________

Age solid foods introduced: ____________

Are there any known food allergies or intolerances? If yes, please explain: ______________________

____

Describe your child's appetite: ____

CHILDHOOD ILLNESSES

Please indicate age of child at time of applicable illnesses:

Chicken Pox: ______________________ Rubella: ______________________

Measles: ______________________ Other (please explain): ____________

Whooping Cough: ______________________ ______________________

Pneumonia: ______________________

Does/has anyone in your immediate family suffer from: *Please circle*

Arthritis Heart Problems Coeliac Diabetes Learning Difficulties Epilepsy

Vision/Hearing Difficulties Allergies Crohn's Mental Health Concerns Asthma

Kidney Disease Developmental Delay Autism Spectrum Disorder ADHD Other

IMMUNISATIONS

Please circle all that apply:

Vaccinations to Schedule Selective Vaccination Conscientious Objector

SLEEP PATTERNS

Day sleeps: ____

Night sleeps: ____

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INFORMED CONSENT TO OSTEOPATHIC CARE FOR BABIES

I hereby request and consent to Osteopathic treatment by any of the following Osteopaths, or any other Osteopath working in this clinic authorized by Ray Power:

- **Dr Ray Power**
  BSc(ClinSc), MHSc(Osteo)
- **Dr Robert De Maio**
  BSc(ClinSc), MHSc(Osteo)
- **Dr Joanne Olsen**
  BSc(ClinSc), MHSc(Osteo)
- **Dr Laura Baldock**
  BSc(ClinSc), MHSc(Osteo)
- **Dr Cybele Todd**
  BAppSc(Clinical), BOsteoSc
- **Dr Leanda Lintzen**
  BSc(ClinSc), MHSc(Osteo)
- **Dr Kate Locke**
  BSc(ClinSc), MHSc(Osteo)
- **Dr Sarahjane O'Leary**
  MOst
- **Dr Madeleine Goodman**
  BAppSc(Comp Med), MOst
- **Dr Allison Smith**
  BAppSc(Comp Med), MOst
- **Dr De-arne Bordin**
  BAppSc(Clinical), BOsteoSc

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, Osteopathy has some risks associated with 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 judgment during the course of treatment, which the Osteopath feels at the time, based upon the facts then known, 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.

I ______________________________ understand that the time I book with my practitioner/s
Parent's Name

is specifically reserved for my child. Therefore **I must give 24 hours' notice to change/cancel appointments;**

otherwise a cancellation fee will be applied.

This enables us to offer your appointment to other patients who require treatment.

You will receive a courtesy reminder the day prior to your appointments.

☐ I do **not** wish to receive the (quarterly) Clinic Newsletter, with health news, updates and offers, or any other articles of interest, via email.

____
Parent's Signature

____
Child's Name

____
Date