west perth osteopathy
whole body health
(08) 9485 2800

Paediatric Patient Information – 2-12 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: _____

Birth Weight: _____ Current Weight: _____

Parents' Email: _____

Address:_____

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

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

Private Health Fund: _____

Exercise/Hobbies (if applicable): _____

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_____

Personal 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, by 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?_____

_____

Length of pregnancy: _____ Type of birth (i.e. hospital/home/etc.): _____

APGAR Score: _____ Summary of feeding (breast / formula): _____

Significant pre-/post-natal events: _____

_____

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

P.T.O.

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MEDICAL HISTORY – *Please indicate any problems below*

	Y	*N*	***Please explain, if ticked YES***
Nerve, Muscle, Bone, Joint Problems e.g. growing pains, headaches			
Heart, Lungs, Respiratory, Circulation Problems e.g. asthma			
Eyes, Ears, Nose, Throat Problems e.g. ear infections, recurring colds/coughs			
Kidney, Bladder, Urinary or Genital Problems e.g. Bedwetting, constipation			
Endocrine/hormonal Problems e.g. Thyroid, diabetes			
Behavioural/Developmental Delay			
Mood or Stress disorder e.g. Depression, Anxiety			
Bowel, Digestive Issues e.g. Constipation, diarrhoea, reflux, Crohns, Collitis, IBS			

Describe any previous or future surgery or hospitalisations your child has or will have: _____

_____

_____

What x-rays, CT Scans or other medical test have been taken in their lifetime? _____

_____

What accidents have they had in their lifetime (e.g. car, or sporting related)?_____

_____

What illnesses has your child previously had? _____

_____

Does your child wear shoe inserts/orthotics? _____

_____

Is/has your child had any major dental work done (ie. tooth extraction, braces, plates etc)? Please describe _____

_____

How would you rate your child's physical health?

□ Excellent □Good □Fair □Poor □Getting Better □Getting Worse

How would you rate your child's general mood and/or emotional/mental wellbeing?

□ Excellent □Good □Fair □Poor □Getting Better □Getting Worse

Does your child have trouble going to sleep or staying asleep? □Yes □No, if so, please explain _____

_____

Does your child have difficulty feeding/eating? □Yes □No, if so, please explain _____

_____

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INFORMED CONSENT TO OSTEOPATHIC CARE FOR CHILDREN (2-12 y.o.)

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