

INFANT REGISTRATION & HISTORY FORM

BACK-IN-ACTION CHIROPRACTIC CLINIC
Pain Relief, Rehabilitation, Prevention and Well-being

28 Cop Lane,
Penwortham,
PRESTON, PR1 0SR
Tel: (01772) 749389
reception@back-in-action.com
www.back-in-action.com

First name/s: Surname:

Sex: Date of Birth: Address:

Name of Parent/Guardian:

Title: Mobile: Tel.: Home

How did you find out about us?	Friend	Family	GP	Web	Facebook	YP	Advert	Other
--------------------------------	--------	--------	----	-----	----------	----	--------	-------

GP Name: Address:

..... Telephone:

HISTORY

Complaint

Type of Problem:

Onset/Cycle:

Duration/Frequency:

Aggravating/Relieving Factors:

Previous Treatment:

Other Problems

Pain:

Fever:

Cold:

Crying (response to holding/feeding):

Very quiet:

Cough:

Vomiting:

Bowels:

Movement problems:

Medication:

Vaccinations:

General Overview

Sleeping patterns: Sleeping position:
Activity: Eye problems:
Eating/growth: Dental treatments:
Ear problems: Headaches:
Colds/flu: Breathing problems:
Waterworks problems: Bowel problems:
Muscular problems: Joint problems:
Balance problems: Growing pains:
Fractures/dislocations/sprains: Hyperactivity:
Inherited conditions: Downs Syndrome
 Cerebral Palsy
Hospitalisations/surgery:
Accidents : RTA:
 Falls from cot/changing nappy:
 Sports Injuries:

During Pregnancy

Any Problems: Medication:
Fever/infection: Vomiting:
Diabetes: Eclampsia:
Toxaemia: Haemorrhage:
Mother's accidents:

During Birth

Hospital/home birth: Normal/difficult birth:
Type of presentation/delivery: Length of labour:
Pain relief used/other medication: Order of birth in family:
Birth weight: Current weight:

Post Birth

APGAR score:

Birth injuries: Breathing problems:

Poor feeder: Crying:

Cyanosed: Rashes:

Jaundiced: Rhesus +/-ve:

Drip fed: Other abnormalities:

Naso-gastric tube: Infections:

Convulsions: Paralysis:

Developmental

The values given in brackets are just a rough guide, considerable variation can be expected.

Smiles (6 weeks): Holds head steady (3mths):

Sits unaided (7mths): Stands supported (9mths) :

Use of walking aid/bouncers: Crawls (11mths) :

2-3 words (12mths): Walks unaided (13mths):

Holds cup and drinks (15mths): 2-3 word sentence (2yrs):

Dresses alone (3yrs): Nappies/toilet training:

School progress:

Diet

Breast fed: Bottle fed:

Feeding position: Types of feed:

Weaning: Winding:

Colic: Feeding (slow/fast/large/small):

Food allergies:

Social

Siblings: Relations with others:

Household environment: Playgroup/daycare:

Maternal age: Paternal age:

Family History

Congenital hip dislocation? : Other orthopaedic problems:

Hereditary conditions?

.....

.....

Informed Consent to Chiropractic Adjustments and Care at Back-in-Action

Before we can start your treatment programme, we need to gain your consent for any procedures we apply.

I have revealed details on all my child's past health issues, medical conditions and medications.	Initial:
--	-----------------

I consent for my child to receive an appropriate physical examination.	Initial:
---	-----------------

Practitioners using manual therapy techniques, such as adjustment, manipulation or mobilisation, are required to inform patients, or their representatives, that there are or maybe some rare risks associated with such treatments. Please read your '**Information for Consent to Chiropractic Care (Patient Copy)**' carefully before your child's first consultation. If you are satisfied please sign. If you want to, you can discuss any issues with your child's Chiropractor before signing.

I have read the 'Information for Consent', I am aware of the potential risks associated with chiropractic treatment.	Initial:
---	-----------------

I have had an opportunity, if I wished, to discuss the nature and purpose of chiropractic adjustments and other procedures in general and my child's treatment in particular as well as the contents of this consent.	Yes / No	Initial:
--	-----------------	-----------------

I confirm that I have received and understood the information given to me regarding my child's case, the proposed treatment and its implications and I hereby consent to treatment as per the plan outlined by my child's Chiropractor. I understand that results are not guaranteed. I understand my child's Chiropractor has many years of training in diagnosis and treatment. I do not expect the doctor of Chiropractic to anticipate and explain all the risks and complications of treatment and I wish to rely on the doctor to exercise best judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my child's best interest.

Initial:

I hereby request and consent to chiropractic adjustments and other therapies performed on my child by my child's Chiropractor to the joints, ligaments, muscles, fascia and nerves of my child's spine (neck and back), pelvis, extremities (shoulder, upper and lower limbs) and head.

I give my Informed Consent for my child to receive treatment and understand that at any time I may withdraw my consent and treatment will be stopped.	Signed:
--	----------------

From time to time we collect information to prepare an anonymised statistical report for research purposes. I give my consent for my child's information to be used in these statistical reports.	Yes / No	Signed:
We may on occasion contact your child's GP, to let them know what we have found and offer recommendations. Do you give your consent?	Yes / No	Signed:
I consent for my e-mail address to be used for follow up information about my child's care and appointment reminders.	Yes / No / NA	Signed:
I consent for my postal address to be used for follow up information about my child's care and appointment reminders.	Yes / No	Signed:
I consent for my mobile number to be used for follow up information about my child's care and appointment reminders.	Yes / No / NA	Signed:
I consent to receiving the Clinic Newsletter.	Yes / No	Signed:
I consent to receiving the Clinic Promotions.	Yes / No	Signed:

PTO

Data Protection / Privacy Policy Summary

Data Protection Act 2018 (GDPR) – Personal Information is to be:

- 1) Processed lawfully, fairly and in a transparent manner
- 2) Collected for specific, explicit and legitimate purposes
- 3) Adequate, relevant and limited to what is necessary
- 4) Accurate and where necessary, kept up to date, with inaccuracies being erased or rectified without delay
- 5) Kept in a form that permits identification of Data Subjects for no longer than is necessary for the purposes for which Personal Data is processed
- 6) Processed in a manner that ensures appropriate security of the Personal Data including protection against unauthorized or unlawful processing and against accidental loss, destruction or damage.

Most Registration Forms are stored in the Clinic and the information on the forms and that of those who have requested Articles and / or Newsletters via the Website is entered in the Clinic Software.

The Clinic Software is backed up securely by our Data Processor Software Supplier to third-party Hosting Companies.

We also keep a list of first names and email addresses of patients and those who have requested Articles and / or Newsletters securely on our Website which is managed by another of our Data Processors.

Personal records are kept for the period required by law and are only released to third parties if authorized by you in writing or if required by a government agency.

You may choose at any time to have your Email Address Unsubscribed and / or to stop receiving mail by notifying us by email or in writing.

I have read and understand the Summary of the Data Protection / Privacy Policy and consent to my child's personal data, and mine to a lesser extent, being held by Back-in Action. I am aware I can ask for a paper copy of the full Data Protection / Privacy Policy at any time or see it on the Back-in-Action website.

Signed:

The content of this form is accurate to the best of my knowledge.

Yes / No

Signed:

Date: