GOULDS
NATURAL MEDICINE
ESTD 1881
CLINIC

OSTEOPATHY - CHILD

Name: _____ Date: _____

Gender: _____ Preferred pronouns (he/she/they): _____ D.O.B.: _____

Address: _____

Suburb: _____ City: _____ State: _____ Post Code: _____

Phone: (Home) _____ (Work) _____ (Mob) _____

Email: _____ Dr: _____

Occupation: _____ How did you find out about our clinic? _____

Emergency contact name: _____ Phone: _____

Parents: _____ Siblings: _____

Hobbies, sports: _____

☐ Please tick if you have any conditions or physical limitations that would make it difficult to use stairs

Purpose of visit:

_____

_____

_____

_____

Has the child been to an osteopath previously? Y / N

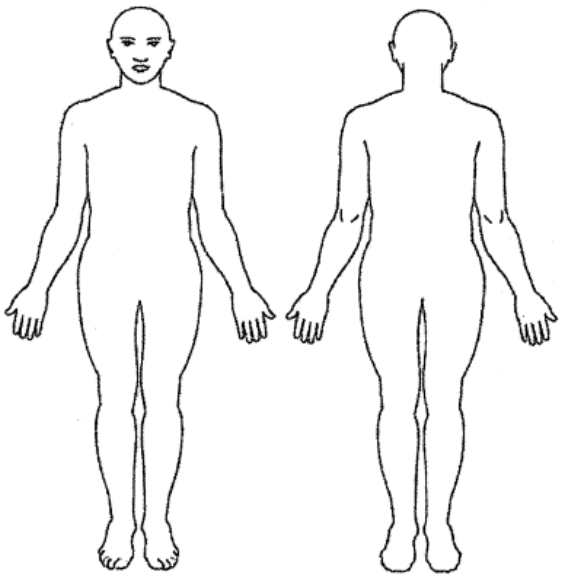
If yes, why and when? _____

_____

_____

Body Map

Please indicate areas of pain/tension/ache



Do you have **private health insurance** cover? YES / NO

If yes, health insurance provider: _____

Do you have an Australian Centrelink issued Health Care or Pension Card? Yes ☐ No ☐

Is this visit related to: Work Cover / MAIB / Other (please specify: _____) / N/A

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Medical history

Does the child take any medication and/or supplements? If yes, please list: _____
_____
_____
_____

Has the child ever had any surgery or hospitalisation? If yes, why and when? _____
_____
_____
_____

Has the child ever had any major accidents, injuries or broken bones? If yes, please list: _____
_____
_____
_____

Does the child from any illnesses and/or allergies? If yes, please list: _____
_____
_____
_____

May we have permission to contact your health professional(s)?

Doctor: _____ Suburb: _____ YES / NO

Specialist: _____ Suburb: _____ YES / NO

Personal trainer: _____ Suburb: _____ YES / NO

Psychologist/Counsellor: _____ Suburb: _____ YES / NO

Podiatrist: _____ Suburb: _____ YES / NO

Chiro/Osteo/Physio: _____ Suburb: _____ YES / NO

Other: _____ Suburb: _____ YES / NO

I give permission for my practitioner to share information about my child's case with other practitioners within Goulds Natural Medicine Clinic and with their General Practitioner if necessary, for the sole purpose of managing my child's needs effectively and safely.

Signed: _____ Date: _____

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Consent to osteopathic care

When performed by a qualified practitioner, osteopathic care is a safe and effective treatment for many conditions. There are, however, risks associated with any treatment. These risks include but are not limited to muscle and joint soreness, fractures, disc injuries and an exacerbation of the presenting complaint. I understand that the results are not guaranteed and I do not expect the osteopath to anticipate all risks and complications. I have read and understood the above and I will ask any questions I have relating to this consent. I intend this consent form to cover the entire course of treatment of my child's present condition, and for other future condition(s) for which I seek treatment. I understand that I can withdraw my consent at any time.

Signed: _____ Date: _____