DUNSBOROUGH OSTEOPATHY

PAEDIATRIC DETAILS

Surname: _____ First Name: _____ Nick name: _____

Parent's names: _____

Postal Address: _____ Post Code: _____

Phone: Home: _____ Mobile: _____

Email: _____

Who referred you to this clinic?: _____

Date of Birth: _____Weeks of gestation: _____ APGAR scores: _____

Please tick if you have noticed any of the following during the past month:

- o Unwell child
- o Failure to thrive
- o Concern about developmental milestones

- o Numbness or weakness

- o Recent trauma
- o Significant loss of movement
- o Asymmetry of movement
- o Limping or gait disturbance

- o Early morning joint stiffness
- o Swelling

- o Significant weight loss

- o Night pain
- o Unremitting pain
- o Pain that wakes from sleep
- o Back pain worse with rest
- o Night sweats
- o Unexplained fever

- o Change in vision, difficulty swallowing or changes in facial expression
- o Severe headache
- o Neck stiffness
- o Decreasing consciousness
- o Progressive chronic headache
- o Morning headaches or nausea

Medications (with reason for taking):

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PAEDIATRIC INFORMED CONSENT TO OSTEOPATHIC CARE

When performed by a qualified osteopath, Cranial Osteopathy is an effective and safe method of treatment for many painful conditions and general health concerns. There are, however, risks associated with any treatment, and I am required to inform you of these.

I hereby request and consent to the performance of Osteopathic treatment on my child by David Bennett.

I understand that results are not guaranteed. I understand, and have been informed that as in the practice of Medicine, in the practice of Osteopathy there are some very slight risks to treatment, including, but not limited to post treatment distress and difficulty settling and/or feeding, fever, skin eruptions, vomiting, wetting/diarrhoea/constipation and fitting/seizure.

I understand that during the course of a treatment, I myself maybe invited to receive treatment. In this circumstance, I understand there are some very slight risks to treatment, including, but not limited to post treatment fatigue or light headedness, emotional distress, muscle and joint soreness, muscle strains, joint sprains, fractures, disc injuries, stroke 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 the treatment, which the Osteopath feels at the time, based upon the facts known, is in my child's best interest.

I intend this consent form to cover the entire course of treatment for my child's present condition, and for any other future conditions(s) for which I seek treatment. I understand that I can withdraw my consent at any time.

I have understood the above-mentioned risks associated with treatment.

Patient Name: ……

Parent or Guardian's name: ……

Patient's date of birth: ……

Parent or Guardian Signature: ……

Date: ……