Childs Information

Welcome to our office

We endeavor to serve you & your family in the best way possible. We ask that you assist us by completing the following information for you child.

Today's Date ___/___/ 20__

Childs Name____

Parents Names: Father ___________________________
Mother ___________________________

Address ____

Suburb _________________________________ P/Code _______

H.Phone ___-______-______ W.Phone ___-_____-_____ Mob.Phone _____- ______- _____- ______

Email address: ____

Date of Birth _____/______/_____ Age ______

Has your child ever received chiropractic care? Yes □ No □

If yes from whom? ________________________________ When? ________________________________

Were x-rays taken? Yes □ No □ Reason for Care? ______________________________

Name of GP_____________________________ GP Clinic _____________________________________

Partner's Name _________________________ Partner's Occupation ___________________________

Names & Ages of Siblings ____

____

____

Referred by: Happy existing patient □ Name: ________________________________
Another Practitioner □ Name: ________________________________
Google □
Flagstaff □
Walked past □
Spinal Screening □
Other __________________________

Your Childs History

What concerns do you have regarding the health of your child?

___

___

Pre- Pregnancy

Did you and the father…	Yes	No	Unsure
Plan and welcome the pregnancy	☐	☐	☐
Prepare their bodies for pregnancy	☐	☐	☐

Pregnancy

For MUM…	Yes	No	Unsure
Have chiropractic care during pregnancy	☐	☐	☐
Exercise throughout pregnancy	☐	☐	☐
Have a nutritious diet during pregnancy	☐	☐	☐
Get injured during pregnancy	☐	☐	☐
Smoke or drink alcohol during pregnancy	☐	☐	☐
Endure Stress during pregnancy	☐	☐	☐

Birth Process	Yes	No	Unsure
Home Birth	☐	☐	☐
Hospital Birth	☐	☐	☐
Was your birth early/late (according to due date)	☐	☐	☐
Induced labor ☐	☐	☐	
Drugs during delivery	☐	☐	☐
Was the delivery long?	☐	☐	☐
Was the delivery difficult?	☐	☐	☐
Caesarean (Elective/Emergency)	☐	☐	☐
Traumatic for your child?	☐	☐	☐
Was your child's head mis-shapen at birth?	☐	☐	☐

Presentation position: (circle) **Posterior, breech, correct, Transverse**

Birth weight ________________________ Apgar Scores _______ _______

How long were you in labour? _______ hours How long did you push for? _______min/hrs

Growth and Development

Physical	Yes	No	Unsure
Physical abuse by siblings/others	☐	☐	☐
Violently pulled by arm	☐	☐	☐
Suffer from colic?	☐	☐	☐
Have they fallen on their head?	☐	☐	☐
Have they fallen down stairs?	☐	☐	☐
Suffer from reflux?	☐	☐	☐

Chemical	Yes	No	Unsure
Was your child breast fed? If so, for how long?	☐	☐	☐
Was your child bottle-fed? If so, for how long?	☐	☐	☐

Vaccines Received

___

Mental/Emotional

	Yes	No	Unsure
Is there communication breakdown in your household?	☐	☐	☐
Is there any stress in the family?	☐	☐	☐

If yes to any of the above, please give details

____

Other Problems

Please indicate by circling any of the following conditions which your child has experienced in the past:

Headaches	Allergies	Neck pain
Back pain	Constipation/Diarrhea	Earaches/Infections
Sinus pain	Recurrent tonsillitis	Bed Wetting
Recurrent chest infections	Growing Pains	Hyperactivity
Loss of appetite	Poor sleeping habits	Visual Disorders
Constant fatigue	Arm/leg pain	Poor co-ordination
Learning Difficulties	Recurrent stomach aches	Digestion disorders
Scoliosis	Fever	Convulsions
Joint Pain	Asthma	Travel sickness
Night Terrors	Seizures	Chronic colds
Recurring fevers	Hip problems	

Other ____

Medical History

Has your child…	Yes	No	Unsure
Ever been assessed for the presence of scoliosis	☐	☐	☐
Had a learning disorder?	☐	☐	☐
Been accident prone?	☐	☐	☐
Been in a motor vehicle accident?	☐	☐	☐
Taken any or is currently on medication?	☐	☐	
Had any diseases / illnesses?	☐	☐	☐
Had any broken bones or sprain injuries? (Please describe)	☐	☐	☐

____

Ever been hospitalized or had surgery? (Please describe)	☐	☐	☐

____

Has your child had significant falls? (Please describe)	☐	☐	☐

____

How long did your child crawl for? _____ months

How many doses…

Has your child of antibiotics?
In last six months ____
During lifetime ____

Of prescription medication has your child taken?
In last six months ____
During Lifetime ____