Leap into Life @ Riverholm Chiropractic

Child Health Questionnaire

General

Name _____ Date of Birth _____

Address _____ Age _____

Home Phone _____ Parent's names _____

Parent's Work Phone _____ Sports/Hobbies _____

Referred By: ☐ Yellow Pages ☐ Other Patient ☐ G.P. ☐ Paediatrician ☐ Other _____

About Your Health

Welcome to Riverholm Chiropactic and congratulations on taking this step toward releasing the true health potential of your child!

The human body designed to be vibrantly healthy. Throughout life, events occur which damage your health. This case history is designed to uncover the layers of damage, especially to the spine and nervous system, which block the expression of your innate wellbeing.

Conception to Birth

When you are very young, including before you were born, you are particularly vulnerable to injury. These early injuries are the most important events influencing your health in later life.

While pregnant with your child, did your child's mother:

Yes	No		Patient Comment
☐	☐	Smoke, or drink alcohol?	_____
☐	☐	Have a poor diet?	_____
☐	☐	Have any falls or injuries?	_____
☐	☐	Have any physical or mental abuse?	_____
☐	☐	Was she sedentary? (not active)	_____

Birth Itself

Even a natural birth can be the most traumatic experience of your life.
Did any of the following occur with your child's birth?

Yes	No		Patient Comment
☐	☐	Premature delivery	_____
☐	☐	Long or difficult delivery	_____
☐	☐	Forceps or vacuum extraction	_____
☐	☐	Caesarean section	_____
☐	☐	Breech or other unusual presentation	_____
☐	☐	Mother given drugs during delivery	_____
☐	☐	Labour induced	_____
☐	☐	Hospital birth	_____

Since Birth

Did any of the following occur?

Yes	No		Patient Comment
☐	☐	Motor vehicle or other accidents	_____
☐	☐	Surgery	_____
☐	☐	Bottle fed	_____
☐	☐	Roll out of bed	_____
☐	☐	Head-banging or rocking	_____
☐	☐	Recurrent childhood sickness	_____
☐	☐	Significant Accidents	_____
☐	☐	Surgery	_____
☐	☐	Given any drugs	_____

Other major and even apparently minor trauma can affect spinal health. If any of the following were prominent in your childhood, please indicate and describe:

☐ Large falls while learning to walk	☐ Falling down stairs	☐ Yanked by the arm
☐ Chair pulled out when sitting down	☐ Child abuse	☐ Physical abuse by siblings

Vaccination is traumatic to the developing immune system. Please outline any vaccines your child has been given.

	Vaccine	Ages Given
1	_____	
2	_____	
3	_____	
4	_____	
5	_____	

Does your child:

Yes	No		Patient Comment
☐	☐	Take vitamin/mineral supplement daily	_____
☐	☐	Eat junk foods/takeaways	_____
☐	☐	Exercise	_____
☐	☐	Sleep long and restfully	_____
☐	☐	Have work stress	_____
☐	☐	Have home stress	_____
☐	☐	Have other stress	_____

Does your child have any trouble with:
(Please underline or circle the relevant answers)

- ☐ Teeth, Eyes, Hearing
- ☐ Coughs, Colds, Flu, Sinus, Asthma, Middle ear
- ☐ Colic, Burping, Reflux, Gas, Bloating, Burning
- ☐ Bowel Movements more than twice per day or less than once per day,
- ☐ Constipation, Loose Stools, Difficult or Incomplete bowel motions
- ☐ Poor Circulation, Cold or Hot Hands or Feet, Varicose Veins, Palpitations,
- ☐ Pins and Needles, Numbness, High Blood Pressure, High Cholesterol
- ☐ Retained Fluid, Swelling, Difficulty or Frequency of Urination, Bedwetting
- ☐ Headaches, Back Pain, Neck Pain, Other Joint Pain, Pain Elsewhere _____
- ☐ Skin Rashes or Itchiness, Hair Falling Out
- ☐ Period Pain, Irregularity or other trouble

Desired Outcomes

What I would like to see from my child's care: _____

_____

Congratulations!

You have just finished an important step toward realizing your child's true potential.
Please take this completed form with you to your initial consultation.

As the twig is bent – so the tree grows.