Kensington **Chiropractic for Health**

Date:_____

HEALTH QUESTIONNAIRE - CHILD

Patient Information

Name: _____ Sex: _____ Age: _____ Birth Date: _____
Surname Given Names

Address: _____ Suburb: _____ Postcode: _____

Mother's Name: _____ Father's Name: _____ Phone:_____

Medical Doctor's name: _____ Practice Address: _____

Siblings Names and Ages: _____ Name of Health Fund:_____

Who recommended you to this Clinic?

☐ Another Patient _____ ☐ Yellow / White Pages ☐ Other_____

General History

What are your concerns about your child's health?

_____

_____

When did this begin? _____ How often does your child have these symptoms? _____

Has this occurred before? _____ When? _____ How often? _____

What do you believe caused your child's condition? _____

Are your child's symptoms getting better, staying the same, or getting worse? (Please circle)

What previous treatment has your child received for this condition, by whom and what were the results of that treatment? _____

Has your child ever been to a chiropractor before? ☐ Yes ☐ No Name of chiropractor: _____

What were the reasons for care? _____ Date of last treatment: _____

How would you rate the care you received? Poor Fair Good Excellent

Reason for leaving: _____

Is your child accident prone? ☐ Yes ☐ No

Describe any significant falls or accidents your child has had? _____

Has your child ever been involved in a motor vehicle accident? _____

Is your child currently taking any medication, if so what are they taking and what are they for?

_____

Has your child been vaccinated? ☐ Yes ☐ No If yes, ☐ Medical vaccination ☐ Homeopathic vaccination

How many times has your child taken antibiotics in the last six months? _____ in their lifetime? _____

Has your child ever been hospitalised or required any surgery, if so when and what for?

_____

Does your child suffer from a learning disorder? _____

Has your child ever been assessed for a scoliosis? _____

What is the type of mattress your child sleeps on? _____ Does your child use a pillow? _____

What is your child's preferred sleeping position? _____

Birth History

Describe the birth of your child by ticking the relevant boxes:

☐ Term ☐ Premature ☐ Overdue

☐ Vaginal ☐ Caesarean

☐ Anterior ☐ Posterior ☐ Breech

☐ Induced ☐ Forceps ☐ Suction / Vacuum

☐ Any other relevant information _____

How long were you in labour for? _____ How long did you push for? _____

What was your child's birth weight? _____ What were your child's APGAR scores? _____

Was the birth traumatic for your child? _____

Was the birth traumatic for you? _____

Were there any delivery complications? _____

Was your child's head misshapen at birth? _____

Health History

Was your child breastfed? ☐ Yes ☐ No If so, for how long? _____

Was your child formula fed? ☐ Yes ☐ No If so, for how long? _____

Did your child suffer from colic? ☐ Yes ☐ No If so was it (circle)? Mild Moderate Severe

Did your child suffer from reflux? ☐ Yes ☐ No If so was it (circle)? Mild Moderate Severe

How would you describe your child as a sleeper (circle)? Very poor Poor Average Good Very Good

How long did your child crawl for ? _____

Does your child suffer from any of the following, please tick the appropriate box(s):

	Migraine
	Headache
	Colic
	Asthma
	Bedwetting
	Recurrent Ear Infections
	Back Pain
	Irritability
	Learning Difficulties
	Allergies
	Reflux
	Recurrent Chest Infections
	Constipation or Diarrhoea

	Back Ache
	Stomach Ache
	Vision Problems
	Scoliosis
	Digestive Disorders
	Poor Posture
	Growing Pains
	Sleeping Problems
	Recurrent Throats Infections
	Arm & Leg Pain
	Poor Co-ordination
	Hyperactivity

I, the undersigned, understand thi I am financially obligated for any fees, with the understanding that this clinic will gladly prepare forms and reports if necessary to enable me to regain reimbursement from insuring companies. Legal opinion is that x-rays remain the property of the clinic, however these will be given to you for you to store for your convenience.

Parent's Signature: _____ Date: _____

INFORMED CONSENT

Chiropractic care is recognised as being an effective method of care and is extremely safe in infants and children. Changes to the law now require all practitioners who treat the spine to warn patients of material risks.

In extremely rare cases, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (approx 1 in 5.85 million). Neck Manipulations. Haldeman, et al. Spine vol 24-8 1999). Whilst this has never occurred in this practice, we are still required to warn. If any adjustments (manipulations) are required you will be tested before hand, as has always been our practise.

Other very slight risks include strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000). [Dvorak study in Principles and Practise of Chiropractic, Haldeman. 2nd Edition.]

Chiropractic adjustments (manipulations) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medication and many other alternatives. (A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993.)

The procedures to be used in your child's case will be described to you after which you will be asked if you have any questions. After speaking with the chiropractor we request that you sign below as your **consent to proceed is required**. Please note there may be a considerable degree of variation in individual patient response.

Child's Name: _____

Parent's Signature: _____ Print name here: _____

Chiropractor's Signature: _____ Date: _____