Family Health Professionals Helensvale Southport Chiropractic Clinic

New Patient History Child (Under 12 years)

File #_____

The completion of this form is a sensible first step prior to experiencing the many benefits associated with chiropractic. This form has been designed to assist with delivering the most appropriate chiropractic treatment and/or identifying any possible risk factors to your health and safety to provide appropriate care and advice.

GIVEN NAMES: _____ SURNAME: _____ DOB:___/___/_____

RESIDENTIAL ADDRESS: _____

SUBURB: _____ STATE: _____ POST CODE: _____

Parent 1 Name: _____ Contact Number: _____

Email Address: _____

Parent 2 Name: _____ Contact Number: _____

Name & age of siblings:_____

How did you hear about us? Yellow Pages_____ Google_____ Signage _____ Staff_____

Clinic Patient (please provide their name so we can thank them) _____ Other _____

YOUR CHILDS HEALTH HISTORY

Would you like your child to receive wellness care Yes / No

Reason for this visit today: _____

_____

Details of past treatment: _____

Do you have any other Health Professionals who have cared for your child: Yes / No

Please list any details here: _____

Date of last spinal Examination? _____

Please indicate any current condition your child may have or has had in the past (please circle):

ADD/ADHD	Abnormal gait/limping	Abnormal Stools	Autism Spectrum
Asbergers Syndrome	Bedwetting	Asthma	Back pain
Colic	Convulsions	Behavioural issues	Constipation
Balance issues	Diarrhoea	Colds/Flu	Recurring fevers
Digestive issues	Difficulty sleeping	Ear Aches	Vomiting
Headaches	Pain in bowel movement	Poor school performance	Unusual attachment to toys/pets
Nose Bleeds	Stomach pain	Extremity pain	Fainting spells
Scoliosis	Unusually clingy	Temper tantrums	Constant crying

Please list any other condition your child maybe experiencing or has had in the past _____

_____

_____

Please turn over

Please indicate if applicable to mothers labour and or delivery

Caesarian	Complications	Homebirth	Induced Labour
Epidural	Longer than 12 hours	Longer than 20 hours	Premature Delivery
Use of Foetal Monitor	Use of Forceps	Use of Vacuum	Vaginal Birth
Other:			

Please indicate or fill out all that apply to your child at birth

Birth Weight	Choking	Circumcision	Crying
Duration of Pregnancy Weeks:	Erythromycin	Feeding by bottle	Breast Feeding
Hep B Vaccine	Medications	Jaundice	Pale
Respirator	Sleeping Concerns	Vitamin K	Other

Injuries/Surgeries

Falls: _____
Head Injuries/Whiplash: _____
Broken Bones/Dislocations: _____
Surgeries: _____
Medications: _____

Has your child ever been involved in a motor vehicle accident? YES / NO
If yes, briefly describe: _____

Any treatment received? _____ Chiropractic? _____

This information is likely to be important. At the very least, it will help us get a better understanding of what's going on with your child's health. The following questions are regarding your child's current health concerns:

Are there any health concerns? _____
If so, for how long has this been occurring? _____
Are there any other conditions being experienced? _____
How long has this been ongoing? _____
How often does your child have this condition? _____
Is the patient on and medication? _____

Please note that any and all information, written or otherwise, that you give us is strictly confidential and is so treated by the entire staff. No information or records will be released to any person, health fund, insurance company or any doctor without the written permission of the patient.

We would like to include you on our email list so you receive our health updates and special offers, please check this box if you DO NOT wish to receive these emails. ☐

I hereby authorize the Chiropractor to perform any necessary diagnostic procedures to fully evaluate my child's condition for the presence of vertebral subluxation.

Patient Name: _____

Parent/Guardian Signature: _____ Date: ___ /___ / 20___