Complete Chiropractic Care

PAEDIATRIC PATIENT HISTORY

Dear Parent,

*It is our pleasure to welcome you to our clinic. Please carefully complete the following questionnaire. Your answers will help us to determine how chiropractic may benefit your child. Please note this is a **postural and spinal examination only**. No chiropractic care will be provided today. If care is required, you will be advised of this and an appointment can be made for a later date.*

Master/Miss: Surname_________________________________ First Name_____________________________

Birth Date____________________

Mum's Name__________________ Dad's Name_____________________ Carer's Name_________________

Address____ Suburb________________________ P/C________

Telephone (H)_______________________ Parent/Carer's Mobile_____________________________________

Email: ____

Other Children's Names: Have they had a previous chiropractic examination?

1. __________________________________D.O.B.____/____/____ Age_____ Yes / No
2. __________________________________D.O.B.____/____/____ Age_____ Yes / No
3. __________________________________D.O.B.____/____/____ Age_____ Yes / No
4. __________________________________D.O.B.____/____/____ Age_____ Yes / No
5. __________________________________D.O.B.____/____/____ Age_____ Yes / No

Name & Location of G.P ____

Name & Location of Paediatrician____

How did you find out about us? ____

Have you visited a chiropractor before? Whom? Y/N____

Sport & Physical Activities____

I would like help for____

____

Other problems I am concerned with____

____

PREGNANCY

Did you require any medication through your pregnancy? Yes / No ___________________________________

Were there any complications through your pregnancy? Yes / No_____________________________________

BIRTH

The birth of your child can give vital clues as to potential spinal problems. Please answer the following questions about the delivery and birth of your child

Home / Hospital Delivery	Drugs during delivery Yes / No
Delivered Normally Yes / No	Breech Yes / No
Posterior Yes / No	Premature Yes / No
At Term Yes / No	Caesarian Yes / No
Late Yes / No	Forceps Yes / No
Chemically Induced Yes / No	Suction Yes / No

Other ____

Baby's Birth weight: ____________________ Apgar Scores ____________

How long were you in labour? ______Hours How long did you "push" for? _____ Mins / _____ Hrs

Do you believe the birth was traumatic for your child? Yes / No

Was your child's head mis-shapen at birth? Yes / No

Were there any delivery complications? Yes / No Details____________________________________

____

BIRTH TO SIX MONTHS

Was your child breast fed? Yes / No For how long? _______________________________

Were there attachment issues? Yes / No Details: _______________________________

Was your child formula fed? Yes / No For how long? __________ Type __________

Did your child suffer with colic? Yes / No If yes, how bad was it? Mild / Moderate / Severe

Did your child suffer with reflux? Yes / No If yes, how bad was it? Mild / Moderate / Severe

(Please indicate by circling any of the following): Would you say your child was a

Very poor sleeper Poor sleeper Average sleeper Good sleeper Very good sleeper

OTHER PROBLEMS

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

Headache	Allergies	Neck pain
Back pain	Constipation/Diarrhoea	Earaches/Infections
Sinus pain	Recurrent tonsillitis	Bedwetting
Recurrent chest infections	Growing pains	Hyperactivity
Loss of appetite	Poor sleeping habits	Visual disorders
Constant fatigue	Arm/ Leg pain	Recurrent stomach aches
Scoliosis	Fever	Convulsions
Joint pains	Asthma	Travel sickness
Night terrors	Seizures Chronic	Colds
Recurring fevers	Hip problems	Digestive disorders
Developmental Delay	Poor social skills	Extremely messy eater

Other ____

SCHOOL AGE CHILD:

Poor co-ordination	Learning difficulties	Poor hand writing
Behavioural Issues	Diagnosed as ADD/ADHD	Delayed verbal communication
Diagnosis of Autism	Difficulty with reading /writing /spelling	Extreme clumsiness

Other ____

MEDICAL HISTORY

What age did your child begin crawling? ________ How long did your child crawl for? __________

Is your child accident prone? Yes / No Has your child has any significant falls? Yes / No

Please describe any falls or accidents your child has had.

____

____

Has your child ever been involved in a motor vehicle accident? Yes / No

Is your child vaccinated? Yes / No

Has your child had any diseases/ illnesses? Yes / No Details: ______________________________

Is your child on medication? Yes / No Details: ______________________________________

Has your child ever been hospitalised or had surgery? Yes / No Details: _______________________

____

Has your child ever had any broken bones or sprain injuries? Yes / No Details:__________________

____

Has your child ever been assessed for the presence of scoliosis? Yes / No

How many times has your child taken antibiotics? In last six months ______ During lifetime ____________

How many doses of other Prescription Medication has your child taken?

In last six months __________ During lifetime _____________

What was the medication for? ____

PREVIOUS CHIROPRACTIC CARE

Has your child had previous chiropractic care? Yes / No

Reason for care ____

Date of last care ____/____/_____ Name of Chiropractor__________________________________

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

Further Comments ____

What are you hoping to achieve for your child through Chiropractic Care?

____

____

Parent/Guardian Signature: ____ Date: ____________________

File Number