Confidential
Patient Information

CHIRO4FAMILY WELLNESS
Family Healthcare ... Naturally

Personal Information Children *5-16 Years*

Who may we thank for referring you? _____

Full name:		**Date:**
Address:	**Suburb:**	**Post Code:**
Parent(s) Phone: Home:	**Mobile:**	**Work:**
Parent's Email address:		
Date of birth child:	**Year at school:**	
Marital status: M S W D	**Mothers name:**	**Fathers name:**
Names & ages of other children:		
Private Health Fund:		
Doctors name & address:		

Addressing What Brought You Into This Office:

If your child has no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the ***"General Health History"*** *.*

Health Concerns

Please list your child's health concerns according to their severity	Rate of severity 1 = mild 10 = worst	When did this episode start?	If they had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

_____

_____

Since the problem started is it: About the same? □ Getting better? □ Getting worse? □

What has been done for this condition? Was it of benefit?

_____

_____

Which activities aggravate your condition? _____

_____

What makes your condition feel better? _____

_____

Other doctors you have seen for this condition:_____

Is this condition interfering with any of the following?

Schooling □	Sleep □	Daily routine □	Sports/exercise □	Other □(please explain):

General Health History

Have your child had any surgery? (Please include all surgery)

1. Type:	When?
2. Type:	When?

Have your child had any accidents and/or injuries: car, sports-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes □ No □
2. Type:	When?	Hospitalized? Yes □ No □
3. Type:	When?	Hospitalized? Yes □ No □

Have they ever had x-rays taken?

Area of body:	When?	Where

Do you wear orthotics or heel lifts? Yes □ No □

Past Health History

Please mark the following conditions your child may have had or have now (**-** have had or **+** have now):

□Allergy	□Arm/Leg Pain	□Asthma	□Back Pain	□ Bowel Problems	□Bed Wetting	□ Chronic Colds
□Chest Infection	□Constipation	□Diarrhoea	□Digestive Pain	□Ear Infections	□Eczema	□Fatigue
□Growing Pains	□ Headaches	□Hip Problems	□Hyperactivity	□Joint Pain	□Learning Issues	□Loss Appetite
□Neck Pain	□ Fevers	□Scoliosis	□ Sinus Pain	□Stomach Ache	□Tonsillitis	□Tight Muscles
□Travel Sickness	□Trouble Sleeping	□Visual Disorder	□ Other			

Other (please explain) _____

Current Medicines and Supplements

Please list any medications your child has taken in the past 6 months and why: (prescription and medication)

_____

_____

Medical History

How long did your child crawl for? _____Months

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

Please describe any falls or accidents your child has had. _____

_____

Has your child had any diseases / illnesses? Yes / No

Has your child ever been hospitalized or had surgery? Yes / No

If yes, please describe: _____

_____

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

If yes, please describe: _____

_____

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

Has your child had a learning disorder? 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_____

Over 70% of our patients bring in their children to get adjusted. If you would like to have your children and or spouse checked for subluxations tick the box below and they can receive a complimentary examination if scheduled within 2 weeks of you starting care. **This exam is no cost to you** and does not obligate them to receive further care. We have several convenient and affordable family plan payment options should family members decide to receive care.

☐ I would like my family members checked for subluxations in the next 2 weeks.

DON'T MISS OUT !

Previous Chiropractic Care

Has your child had previous chiropractic care? Yes / No

Reason for care _____

Date of last care_____ /_____/_____Name of Chiropractor _____

Location of Clinic_____Were x-rays taken? Yes / No

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