Confidential
Patient Information

CHIRO4FAMILY
WELLNESS
Family Healthcare ... Naturally.

Personal Information Children *0-5 Years*

Dear Parent,

Please complete the following questionnaire. Your answers will help us to determine whether chiropractic can help your child. Please note this is a postural and spinal examination only. If treatment is required you will be advised of this.

Thank You

Name of Child: _____D.O.B.: _____ /_____/_____Age:_____

Parents Names: Father _____
Mother _____

Address:_____

_____

Contact Phone Numbers:

Home _____Mobile _____Work _____

Email _____

Other Children's Names:

_____ D.O.B. ____/____/_____Age _____
_____ D.O.B. ____/____/_____Age _____
_____ D.O.B. ____/____/_____Age _____
_____ D.O.B. ____/____/_____Age _____

How did you hear of the postural and spinal examination offered in this clinic? (please circle)

Staff Member / WorkShop / Friend / Family / Sign in Reception / Advertisement / Other

Do you have private health insurance for chiropractic? Yes / No / Unsure

Name of company _____

What concerns do you have regarding the health of your child? _____
_____
_____
_____
_____
_____
_____

BIRTH

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

Was you child 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/Vacuum	Yes / No

Other_____

Birth weight _____
How long were you in labour?____Hours How long did you "push" for?_____Mins /Hours
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? _____

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 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 which 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	Poor co-ordination
Learning difficulties	Recurrent stomach aches	Digestive disorders
Scoliosis	Fever	Convulsions
Joint pains	Asthma	Travel sickness
Night Terrors	Seizures	Chronic Colds
Recurring Fevers	Hip Problems	Other

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

Is your child on medication? Yes / No
Vaccination History? _____

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