Confidential Patient Information - Child up to 12 Years of Age

Thank you for allowing us to be involved in the improvement of your child's Health & Wellbeing!

It is *essential* that you complete all the following questions to the best of your ability. These questions are all relevant to your child's health & our proposed Chiropractic care plan. Failing to provide information could affect your child's capacity to respond to treatment & prevent inappropriate treatment being provided.

Surname: ..... Given name: ..... Date of Birth: .....

Preferred Name: ..... Male / Female Baby / Toddler / Pre-schooler / Student

Address: .....

Suburb/Town: .....Postcode: ..... Home Ph: .....

Mother's Name: .....Phone (H) ..... Phone (W) .....

Father's Name: .....Phone (H) ..... Phone (W) .....

Who is responsible for making appointments? **Mother / Father / Other** (Full Name).....

Other Children's names: (Please include their birthdates and gender.) .....

.....

We are grateful that our practice grows by referral. Who may we thank for referring you?

Referred by: ❑ Family/Friend - Name: ..... ❑ Clinic Sign ❑ Newspaper

❑ Family Doctor - Name: ..... ❑ Internet ❑ Yellow pages

What concerns do you have regarding the health of this child? (Your reason for contacting us?)

.....

.....

When did this start? .....

What caused it? .....

Is your Child's condition/pain: Worsening Stable Improving (Please circle)

What makes it worse? .....

What makes it better? .....

Previous assessments or tests (Xrays, MRI/CT Scan, Blood Tests): .....

Previous treatments (Doctor, Chiro, Physio): .....

Was there any of the following prior to, or during the onset? (Please circle)

	Trauma	Night Sweats	Night Pain	Illness/Infection
	Dizziness	Unsteady Walking	Nausea	
Or Changes to:	Weight	Appetite	Vision	
	Behaviour	Mental Alertness	Bladder/Bowel Control	

Are your child's symptoms worse at night or any specific time of the day? **Yes / No** please describe:

.....

Does your child's current problem involve any Pain / Tingling / Numbness / Weakness or 'Weird' sensations in either arm or leg? **Yes / No** If **Yes**, where? .....

Please list any **current** or **recent Medications:** (Prescription, Over the Counter, Vitamins, Herbal Supplements etc.)

……

Have any **family members** suffered from any serious or hereditary diseases? (E.g. cancer, diabetes, heart disease or any other major health problem) **Yes / No** Please Explain: ……

At the Child's Birth: - Explanations:

Was the baby Premature/At Term/Late? (Please circle) ……

Was it chemically or physically induced? **Yes / No** ……

Was Doctor assistance required? **Yes / No** ……

Was the child's head pulled to assist delivery? **Yes / No** Forceps or Vacuum? ……

Was a Caesarean Section performed? **Yes / No** ……

Were drugs used in the delivery? **Yes / No** ……

Was the delivery difficult? **Yes / No** ……

Did the child present breech or posterior? **Yes / No** ……

Was the child's head bruised or misshapen? **Yes / No** ……

What were the APGAR Scores at 1 min _____ 5 min _____

What was the length of the Labour? Stage 1 …… Stage 2 …… Total Hrs ……

What was the birth weight? …… lb …… ozs …… kgs

As a newborn Explanations:

Did the child feed? **Breast / Bottle** If Breast, how Long at the Breast? …… months

Did the child favour/prefer feeding on one side of the breast? **Yes / No** Right or Left ……

Did the child have Reflux, Colic, Diarrhoea or Constipation? **Yes / No** ……

Was the child settling after feeding? **Yes / No** ……

Did the child sleep on a 3-hour cycle? **Yes / No** ……

Was the child checked by a Maternal & Child Health Nurse/Paediatrician? **Yes / No** ……

Were any problems detected? **Yes / No** ……

Was the child given any medication orally or otherwise? **Yes / No** (What & why) ……

Did it cause any change in the child's behaviour or eating-sleeping patterns? **Yes / No** ……

Did the child ever fall more than 1or 2 feet? **Yes / No** ……

As a crawler/ walker

What age did they start **crawling**? …… months

How did they crawl? **Opposite Arm & Opposite Leg** Y / N **Commando** Y / N **Bottom Shuffle** Y / N

What age did they start **pulling themselves up**? …… months

What age did they start **walking**? …… months

Was the child checked by nurse or paediatrician? **Yes / No** Any problems found? ……

From Birth until Now

		Explanations:
Has your child been **Knocked Unconscious?**	**Yes / No**	……
Had a **Broken Bone** or spinal injury?	**Yes / No**	……
Been **Hospitalised** or had surgery?	**Yes / No**	……
Had usual **Vaccination**(s)?	**Yes / No**	……
Has your child been **Accident Prone?**	**Yes / No**	……
Has your child had a **Significant Fall/Accident?**	**Yes / No**	……
Has your child had a **Scoliosis Examination?**	**Yes / No**	When? By Whom? ……
Has your child a **Learning Disorder**?	**Yes / No**	……
Has your child a **Poor Posture**?	**Yes / No**	……

If you could **improve one aspect of your child's HEALTH or behaviour**, what would it be?

.....

How many hours does your child spend in prolonged time sitting? …… Hours

How would you rate your child's diet? **Excellent / Good/ Fair / Poor**.....

Has your Child *EVER* experienced *any* of the following?

❑ Neck Pain	❑ Throat Infections	❑ Constipation	❑ Fatigue
❑ Lower Back Pain	❑ Ear Infections	❑ Diarrhoea (loose bowels)	❑ Nervousness
❑ Hip Troubles	❑ Bloody Nose	❑ Allergies	❑ Temper Tantrum
❑ Knee Troubles	❑ Bladder Infections	❑ Seizures/Epilepsy/Fits	❑ Hay fever
❑ Foot/Ankle Troubles	❑ Crossing of Eyes	❑ Irritability	❑ Sleep Disturbances
❑ Shoulder Troubles	❑ Co-ordination Problems	❑ Eczema/Rashes	❑ Speech difficulties
❑ Arm/Elbow/Wrist/Hand	❑ Balance Problems	❑ Milk Intolerance	❑ Stress at home
❑ Sinus Troubles	❑ Restless Legs	❑ Breastfeeding difficulties	❑ Stress, other
❑ Poor Posture	❑ Limping	❑ Colic / Reflux	❑ Hyperactivity
❑ Hearing Troubles	❑ Growing Pains	❑ Breathing Problems	❑ ADD/ ADHD
❑ Light Headedness	❑ Bedwetting	❑ Digestive Troubles	❑ Head Banging
❑ Headaches/Migraine	❑ Learning Difficulties	❑ Vague Abdominal Pains	❑ Asthma

Please Rate your Child's general health out of 10: ……. **/10** (10 = Healthy and 1 = Very Unwell)

Is your child covered by a private Health Fund for Chiropractic Care? Yes / No / Unsure

Name of Health Fund ..... 2 Digit ID ☐☐

Are any of the following involved? **WorkCover:** **Veterans' Affairs:** **TAC Claim:**
*** **If Yes, please speak to our Chiropractic Assistant before your appointment** **Yes / No** **Yes / No** **Yes / No**

(Please circle) (*We do not accept TAC Claims)*

Please read the following information carefully before signing.

- I have disclosed any past or current illness, surgery, previous trauma, medications, drug use and any known health risks in the forms and questionnaires provided, and **agree to provide any related new information** during the period of care at this clinic or by practitioners who have assessed or treated my child at this clinic.

- I consent to my child undergoing assessment and understand that I may withdraw my consent at any time.

- If during the course of your child's examination, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specialises in that area.

- I consent to the Chiropractor discussing any relevant details of my child's care with His/Her General Practitioner or Specialist where appropriate.

GP's Name: ..... **Address:** .....

Patient's Name: ..... **DOB:** .....

Parent's Signature: ..... **Date**: .....

Parents' Name here: (please print) .....