ANDERSON FAMILY
CHIROPRACTIC
Health Centre

Child's Information:

Date:_______________

Full Legal Name: ____

D.O.B:______________________ Preferred Name: ______________________________

Postal Address:____

Suburb:_______________________________________ Post Code:_________________

Siblings (Names & Ages): ____

Date of last visit to a Chiropractor: ___________________ City: _____________________

Previous Chiropractic Centre: ____

Which parent it is best to contact regarding appointments: Parent 1 / Parent 2

Parent 1's Name & Mobile: ____

Parent 2's Name & Mobile: ____

Email Address of a Parent:____

The biggest compliment to our clinic is the referral of your Family & Friends. **If you heard about us from a person**, please fill in their name so we can show them our appreciation:

____

If it wasn't from a person, how did you hear about us?_____________________________

Section 1:

In this section we aim to find out as much as we can about your child so we can evaluate the best treatment methods tailored to their needs. This ensures you & your child can get the most from their appointments. We appreciate as much detail as possible. We understand that privacy is important, if you prefer to discuss some details verbally, please let a Chiropractic Assistant know.

Please tick this box if your child is presenting for wellness/maintenance care AND has no symptoms: ☐ ***Please advance to Section 2.***

What is the main reason for your child's visit?: ______________________________________

____

What is the pattern of this problem?

☐ Constant ☐ On & Off ☐ Occasional ☐ Cyclical

How long have you/the child noticed this problem?: _________________________________

When this problem is at its worst, how does your child feel?: __________________________

____

If known, what aggravates the problem?: ____

What gives the child temporary relief?: ____

What have you/the child tried that HASN'T worked?:_________________________________

Does your child experience any of the following:

☐ Headaches
☐ Back Pain
☐ Colic/reflux
☐ Allergies
☐ Diarrhoea
☐ Behavioural Issues
☐ Hyperactivity
☐ Sinus Issues
☐ Growing pains
☐ Asthma
☐ Constipation
☐ Fatigue
☐ Anxiety
☐ Other:_________________________________

____
☐ Neck Pain
☐ Ear aches/infections
☐ Sleeping problems
☐ ADD/ADHD symptoms
☐ Stomach problems
☐ Autistic symptoms

Section 2:

In this section we ask questions that look at the body from a broader scope. Again, as much detail as possible is appreciated as things seemingly irrelevant can provide valuable insight to your child's treatment approach. It can also reveal other ways in which chiropractic may benefit your child.

Has your child suffered from any **major illnesses** or **accidents**? Please list and include **when they occurred** and **if it required hospitalisation**:____________________________________

____

Does your child currently take any **medications** or **supplements**? Please list them including **dosage** and **purpose**:____

____

Has your child ever taken antibiotics? If yes, what for?: ______________________________

____

Have any of the following occurred:

- ☐ Fall from change table/crib
- ☐ Tumble down stairs
- ☐ Tonsillitis
- ☐ Involved in a car accident
- ☐ Play in a jumper/walker
- ☐ Frequent fevers
- ☐ Accident in the playground
- ☐ Trouble gaining weight
- ☐ Frequent Colds
- ☐ Frequent crying spells
- ☐ Use a Bumbo/sitting aide
- ☐ Learning difficulties

Was/is the child breastfed? If so, for how long?: ____________________________________

What formula did/do you feed them?: ____

Let us know about the pregnancy: ***If you are unsure of an answer, please leave blank.***

How long was the child in the womb? (eg 36 weeks 2 days): ___________________________

Were there any birthing complications?: ____

How many Ultrasounds did you have during the pregnancy?: __________________________

Was the child exposed to any medications in utero? Please list the type & purpose: _______

____

Please tick any of the following which are applicable to the delivery:

☐ Natural Birth ☐ C-section ☐ Use of forceps

☐ Vacuum extraction ☐ Induced labour ☐ Use of Epidural

☐ Baby's APGAR score:_________ ☐ APGAR score at 5 minutes: _________

Do you have any concerns or additional information to let us know?______________________

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____

____

Name of Child:____

Name & Signature of Legal Guardian:____

Date:____