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 is it best to contact regarding appointments? Please Select

Parent 1's Name & Mobile: _____

Parent 2's Name & Mobile: _____

Preferred Email Address: _____

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	☐ Sinus Issues	☐ Neck Pain
☐ Back Pain	☐ Growing Pains	☐ Ear aches/infections
☐ Colic/reflux	☐ Asthma	☐ Sleeping problems
☐ Allergies	☐ Constipation	☐ ADD/ADHD symptoms
☐ Diarrhoea	☐ Fatigue	☐ Stomach problems
☐ Behavioural Issues	☐ Anxiety	☐ Autistic symptoms
☐ Hyperactivity	☐ Neck Pain	Other: _____

_____

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 your 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? _____

_____

_____

_____

_____

Name of Child: _____

Name & Signature of Legal Guardian: _____

Date: _____