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Chiropractic Balance: Child Patient History Form

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Child's Name			**Todays Date**
Address			
M / F	**Date of Birth**	**GP Name**	
Guardian's Name		**Guardian's Email**	
Ph (preferred)		**Ph (alternative)**	
Who or what referred you to Chiro Balance?			
Primary reason for consulting our centre (please describe)			
Other problems you are concerned with			

Welcome! Some of the following information is required legally & the rest assists in uncovering the stressors affecting your child's spine & nervous system & their healing potential. Don't worry if many of the questions do not relate to your child. It's OK for children to be happy & healthy & still benefit from Chiropractic care.

Pregnancy

Y N Falls, Injuries, Back Pain
Y N Suffer illness or health challenges
Y N Stressful pregnancy
Y N Excessive morning sickness
Any comments ____________________________

Birth

Premature / On time / Late (circle)
Initiation of labour: Natural / Induced
Length of Labour ______________
Birth Weight __________________
Y N Assistance: Forceps / Ventouse
Y N Caesarean section (Emerg / Elective)
Y N Epidural/Syntocinon/Gas/Pethidine/Other
Any other comments ________________________
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Since Birth

Y N Latching problems
Breast fed / Formula fed / Both (Please circle)
Y N Preference for feeding side
Bowel Movements per day ______
Y N Dislikes lying on back
Y N Dislikes lying on tummy
Y N Other preferred or disliked positions
Y N Not sleeping well, difficult settle
Y N Rocking, arching or head banging
Y N Recurrent sickness (ear, stomach, etc)
Y N Significant accidents (breaks, head injury)
Y N Slow to meet milestones (eg. roll, sit, walk)
Y N Given any medication (eg. antibiotics, pamol)

Issues with any of the following?

Y N Teeth, eyes, ears, throat infections
Y N Speech, concentration
Y N Coughs, colds, asthma, fevers
Y N Colic, burping, reflux, bloating, gas
Y N Digestive or Bowels
Y N Urination, bedwetting
Y N Social behaviour
Y N Heart, circulatory, pins & needles, numbness
Y N Skin rashes, itchiness, hair falling out
Y N Bruises easily, tired all the time
Y N Muscle weakness, in-coordination, fall / bump frequently
Y N Headaches, neck/ joint/ back pain
Y N Learning difficulties
Y N Anxious/Nervous

General Lifestyle

Y N Play sport/recreational activities >5hrs/week
Y N Good appetite
Y N Eats Breakfast
Y N Drinks pure water everyday
Y N Eats variety of fruit, vege, meat
Y N Food sensitivities/allergies _________________
Y N Vitamin/mineral supplement daily
Y N More than 15hrs screen time a week
Y N Childhood Illnesses (eg. Chicken pox, measles)
Y N Vaccinated (Full/Partial)
Y N Vaccination reactions (eg. diarrhea, fever, rash)
Y N Have stress in their life (Home, school, sibling)
Y N Have friends, socialise comfortably
Y N Good Sleeping Habits

I have filled in this form to the best of my knowledge. I understand that no accounts are rendered & the fee for service rendered is due at time of service. For ACC clients: I understand that if my claim is not accepted that I am liable for the outstanding charges. I consent to the use & disclosure of my personal information by Chiropractic Balance to other health professionals who are involved in my health care.

I _______________ as the legal guardian of the above-mentioned child consent to ______________ receiving a chiropractic examination and chiropractic adjustments. Signature____________________