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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) **Date**		
Other problems you are concerned with		

Overall Health History Review

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 _____
_____

Since Birth

Breast fed/ Formula fed / Both
Y N Latching problems
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

Overall Lifestyle Review *(please circle, 10=Poor 1=Ideal)*

Under 2 years old fill in left side only (Over 2 years fill in both)

Movement & Flexibility	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
	Stiff &/or Uncomfortable									Flexible & Comfortable
Sitting Copy rating above if your child is not sitting yet	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
	Slouch &/or uncomfortable									Sit confident, balanced & comfortable
Posture &/or Head Shape	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
	Unbalanced &/or uneven									Balanced & even
Overall level of energy	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
	Wake exhausted &/OR easily tires, often lethargic									Wake up with energy & has good stamina
Sleeping	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
	Difficult &/or wake frequently, restless or uncomfortable									Fall asleep easily & deep sleep
Car Travel	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
	Uncomfortable &/or dislike									Travels well
Bowel Movements	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
	Less than 3 per week &/OR strain to pass &/OR inconsistent									1-3 per day & pass easily/quickly

Physical Ability & Coordination	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
	Ability below peers &/OR low coordination/balance									Ability at or above peers, good coordination/balance
Daily Movement/ Sports/ Activity	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
	Minimal daily movement OR causes pain OR doesnt enjoy									Active & enjoys being active
Overall ability to cope with life	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
	Anxious &/OR easily overwhelmed									Relaxed & cope well Can cope with change
Learning & Behaviour	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
	Ability below peers &/OR behaviour issues									Learns with ease, level & behaviour is age appropriate
Appetite & Eating Habits	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
	Low appetite &/OR low nature based foods									Good appetite & majority nature based diet
Water	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
	No water									1L+ filtered water/ day & drinks regularly
Recovery & Illness	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
	Frequent Illness &/OR slow healing time									Occasional illness & heals/recover quickly

Under 2 year olds: Total _____ *(please add up)*

77 - ____ (total above)/70 x100 = **_____%**

Over 2 year olds: Total _____ *(please add up)*

154 - ____ (total above)/140 x100 = **_____%**

Is there anything else we should know about your child?

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 _____