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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			

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)

Posture & Movement	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
	Unbalanced posture/mvmt &/OR uncomfortable/pain									Balanced posture/mvmt maintained with ease
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
Stretching & Flexibility	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
	Stiff &/or uncomfortable									Flexible & balanced movement
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 _____