Paediatric Form

DATE ___/____/____

It is a pleasure to welcome you to our family of happy and healthy Chiropractic clients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

SURNAME ____ GIVEN NAMES ______________________________________

ADDRESS ____

SUBURB____ POSTCODE _________________

PHONE (AH) ____________________ BH: ____________________ MOBILE: ______________________________________

DATE OF BIRTH ____________________________ SEX: __________________

FULL NAMES PARENTS/ GUARDIANS: ____

PRIVATE HEALTH COVER – NO ◯ YES ◯ HEALTH FUND NAME ____

EMERGENCY CONTACT NAME & PHONE NUMBER ____

HOW DID YOU HEAR ABOUT U?

◯ WEBSITE ◯ DIRECTORIES ◯ SIGNAGE ◯ OTHER (please specify) ________________________________

◯ REFERRED BY ANOTHER CLIENT - NAME ____

◯ PROMOTION / EXPO (please specify) ____

◯ Would you like to receive an SMS for future appointments? (Chiro/Massage appointments)

◯ Would you like a family member or friend to receive a $10 gift voucher? If YES, please provide email address
(For New Chiro and Massage Clients Only)

NAME ____

EMAIL ____

What is the purpose of your visit? ____

Other Doctors seen for this condition? No ◯ Yes ◯ Doctor's Names and Prior Treatments: ______________________

____

Other Health Problems? ____

Check any of the Following Conditions your Child has Suffered from:

◯ Ear infections	◯ Scoliosis	◯ Seizures	◯ Back pains
◯ Chronic cold	◯ Headaches	◯ Digestive	◯ Car accident
◯ Asthma/Allergies	◯ Recurring fevers	◯ Bed wetting	◯ ADHD
◯ Temper tantrums	◯ Colic	◯ Other ____	

Previous Chiropractor: ____

Date of Last Visit: _____/_____/_____ Reason: ____

Name of Paediatrician: ____

Date of Last Visit: _____/_____/_____ Reason____

Are you satisfied with the Care Your Child has Received there? Yes ◯ No ◯

Number of Doses of Antibiotics Your Child has Taken:

During the last six months: ____________, Total during his/her lifetime: _____________

List: ____

Vaccination History: ____

Prenatal History:

Name of Obstetrician/Midwife: ____

Complications During Pregnancy? Yes ◯ No ◯

List: ____

Ultrasound During Pregnancy? Yes ◯ No ◯ Number _________

Medications During Pregnancy / Delivery? Yes ◯ No ◯

List: ____

Cigarette / Alcohol Use During Pregnancy? Yes ◯ No ◯

Location of Birth: ◯ Hospital ◯ Birthing Centre ◯ Home

Birth Intervention: ◯ Forceps ◯ Vacuum Extraction ◯ Caesarian Section (c-section)

Emergency or Planned ? (Please circle)

Complications During Delivery? Yes ◯ No ◯

List: ____

Genetic Disorders or Disabilities: Yes ◯ No ◯

List: ____

Birth Weight: _______________ Birth Length: ______________ AGPAR Scores: ________, ___________

Feeding History:

Breast Fed: Yes ◯ No ◯ How long: _______________

Formula Fed: Yes ◯ No ◯ How long: _______________ Type: ____

Introduced to Solids at: ____________ Months, Cow's Milk at ____________ Months

Food / Juice Allergies or Intolerances: Yes ◯ No ◯

List: ____

Development History

According to National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? Yes ◯ No ◯

Has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? Yes ◯ No ◯

List: ____

Has your child ever been involved in a car accident? Yes ◯ No ◯

List: ____

Other Traumas Not Described Above? Yes ◯ No ◯

List: ____

Any Surgeries? Yes ◯ No ◯

List: ____

Childhood Diseases:

Chicken Pox: No ◯ Yes ◯ Age ______ Mumps: No ◯ Yes ◯ Age ______

Rubella: No ◯ Yes ◯ Age ______ Whooping Cough: No ◯ Yes ◯ Age ______

Rubeola: No ◯ Yes ◯ Age ______ Other: (please specify) __________________________ Age _____