BEINGWELL HEALTHCARE

Inspiring individuals and families to live happier and healthier lives

PAEDIATRIC INITIAL CLIENT FORM

CONFIDENTIAL PATIENT INFORMATION

DATE: ____________________

ABOUT YOU

GIVEN NAMES ______________________________ SURNAME ______________________________

ADDRESS

____

SUBURB______________________________ POSTCODE ______________________________

MOBILE ______________________________ WORK NUMBER ______________________________

EMAIL ______________________________

DATE OF BIRTH ______________________

PRIVATE HEALTH COVER – ◯ NO ◯ YES HEALTH FUND NAME______________________________

EMERGENCY CONTACT NAME & PHONE NUMBER

____

HOW DID YOU HEAR ABOUT US ? ◯ WEBSITE ◯ SIGNAGE ◯ FACEBOOK ◯ INSTAGRAM

◯ OTHER ____

◯ Would you like to subscribe to our email marketing database

◯ 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 ______________________________

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PURPOSE OF YOUR VISIT

What is the purpose of your visit?____

Have you seen another doctor for this? No ◯ Yes ◯ Doctors Name: ___________________________

Please list prior treatments:

____

Other Health Problems?

____

Check any of the following conditions your child has suffered from:

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

◯ Other ____

Previous Chiropractor: ____ Date of Last Visit _____/_____/_____

Reason: ____

Previous Pediatrician: ____ Date of Last Visit _____/_____/_____

Reason: ____

Are you satisfied with the care your child has received there? ◯ Yes ◯ No

Has your child taken antibiotics: in the last 6 months ◯ Yes ◯ No

How many times: __________________

List:

____

Vaccination History:

____

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PARENTAL HISTORY OF INFANT CLIENTS:

Name of Obstetrician/Midwife: ____

Complications during pregnancy? ◯ Yes ◯ No

Please Detail:____

Ultrasound during pregnancy? ◯ Yes ◯ No Number _____________

Medication during pregnancy/delivery? ◯ Yes ◯ No

List: ____

Cigarette/Alcohol consumption 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: ________________________________

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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 _____
Rubella: No ◯ Yes ◯ Age ______
Rubeola: No ◯ Yes ◯ Age ______

Mumps: No: ◯ Yes: ◯ Age ______
Whooping Cough: No: ◯ Yes: ◯ Age ______
Other: (please specify) ___________________________