Confidential Child Information

Child's Name_____ Date / /

Parents/Guardians Names _____

Address_____

Email _____

Mobile Number _____ Other Number _____

Sex: M ☐ F ☐ Weight _____ Height _____ DOB: / / Age: _____

Who may we thank for referring you? _____

The reason for your child's visit today ?_____

When did this problem start? _____

Have they had this before? Y ☐ N ☐ If yes, when? _____

What has made it better / worse ? _____

Has your child seen any other Health Practitioner about this problem? Y ☐ N ☐

Name / Prior treatment _____

Other health concerns ? _____

Has your child experienced any of the following problems in the past?:

☐ Ear infections	☐ Scoliosis	☐ Seizures	☐ Chronic colds
☐ Asthma/Allergies	☐ Moodiness	☐ ADHD	☐ Recurring fevers
☐ Growing/Back pains	☐ Colic	☐ Bed wetting	☐ Bad temper
☐ Digestive issues	☐ Headaches	☐ Other (specify) _____	

Is there any family history you think may be relevant? Y ☐ N ☐ (if yes please specify)

_____

Previous Chiropractor (if any) _____

Date of last visit: _____ Reason _____

Name of GP _____

Date of last visit: _____ Reason _____

Number of doses of Antibiotics your child has taken ?

Last 6 months _____ Lifetime _____

Number of other medications your child has taken ?

Last 6 months _____ Lifetime _____

PRE NATAL HISTORY:

Name of Obstetrician/ Midwife : _____

Complications during pregnancy: Y ☐ N ☐ please specify: _____

Medications during pregnancy / delivery: Y ☐ N ☐ please specify:_____

_____

Cigarette / Alcohol use during pregnancy:Y ☐ N ☐

Location of birth : Hospital _____ Birthing Centre ☐ Home ☐

BIRTH INTERVENTION:

Caesarean section : Planned ☐ Emergency ☐

Forceps extraction ☐ Vacuum Extraction ☐

Complications during delivery: Y ☐ N ☐ List: _____

Genetic disorders or disabilities: Y ☐ N ☐ List: _____

Birth weight : _____ Birth length : _____

FEEDING HISTORY:

Breast fed : Y ☐ N ☐ How long _____

Formula fed : Y ☐ N ☐ How long _____

Introduction to solid foods _____ months Cow's milk at _____ months

Food / Juice allergies or intolerances : Y ☐ N ☐ List:_____

_____

DEVELOPMENTAL HISTORY :

At what age was your child able to:

Respond to sound _____ Respond to visuals _____ Cross crawl _____

Hold head up _____ Sit up _____ Stand alone _____

Walk alone _____ Speak first words _____

Is / Has your child been involved in any high impact or contact sports: Y ☐ N ☐

List : _____

Has your child ever been in a car accident: Y ☐ N ☐ How many _____

Has your child ever been seen for an emergency: Y ☐ N ☐ List :

Other traumas not listed : _____

Prior Surgery : _____

Menarche: Y ☐ N ☐ Age:_____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to examine and administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

_____ _____ _____

SIGNED NAME DATE