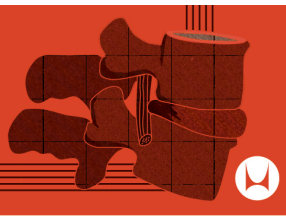
GONSTEAD CHIROPRACTOR
Hoyne Chiropractic . 0424 176 405



Chiropractic – child health questionnaire l 0-5 years

The information on this form is and will remain strictly confidential

Please read the following sections carefully and write your answer / tick where appropriate.

PATIENT DETAILS

Child's Name: _____ M / F Date of Birth: __/__/____ Age: _____
Parent / Guardian's Name: _____
Address: _____
City: _____ State: _____ Postcode: _____
Telephone (Home): _____(Mobile): _____(Work): _____
Email: _____

Name of Paediatrician / Doctor: _____
Telephone: _____

Is your family a member of a Private Health Fund that covers Chiropractic Care? ◯ YES ◯ NO
Name of your Fund: _____

Who referred you to this Chiropractic Office?: _____

Current concern with your child: _____

PRE-NATAL HISTORY (CONCEPTION to BIRTH)

While pregnant, did the mother:
Smoke / or Drink Alcohol during Pregnancy? ◯ YES ◯ NO List: _____
Take any Medications during Pregnancy? ◯ YES ◯ NO List: _____
Have Illness / Complications during Pregnancy? ◯ YES ◯ NO List: _____
Have any falls / traumas during Pregnancy? ◯ YES ◯ NO List: _____
Have Ultrasounds During Pregnancy? ◯ YES ◯ NO Number: _____
Duration of Pregnancy in weeks: _____ Age of Mother at time of Birth: _____

PERI-NATAL HISTORY (BIRTH)

Place of Birth: ◯ Hospital ◯ Birthing Centre ◯ Home
Provider: ◯ Midwife ◯ Medical Doctor ◯ Other
Child's Birth Weight: _____ APGAR Scores: @1min _____ @5min _____ ◯ Unsure

Type of Birth:
◯ Natural
◯ Emergency Caesarean Section
◯ Planned Caesarean Section

If not Caesarean Section was other birth intervention required?:
◯ Forceps Extraction
◯ Vacuum Extraction

Use of Drugs during birth?: ◯ YES ◯ NO Was the labour chemically induced?: ◯ YES ◯ NO
Complications during Delivery?: ◯ YES ◯ NO List: _____
Genetic Disorders or Disabilities: ◯ YES ◯ NO List: _____

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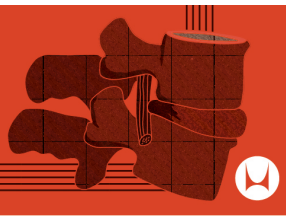

NEO-NATAL HISTORY

Immediately after Birth/During Infancy, did any of the following occur?

Need for child to be reseparated? ◯ YES ◯ NO
Need for child to be in a humidicrib? ◯ YES ◯ NO
Administered medications? ◯ YES ◯ NO List:_____
Recent illness? ◯ YES ◯ NO
Surgery? ◯ YES ◯ NO
Difficulty Feeding / Latching / Sucking? ◯ YES ◯ NO
Breast Fed: ◯ YES ◯ NO How Long: _____
Formula Fed: ◯ YES ◯ NO How Long: _____
Type: _____
Introduced to Solids at:_____ months, and Cows' milk at_____ months
Failure to grow/gain weight? ◯ YES ◯ NO
Disrupted sleep patterns? ◯ YES ◯ NO
Hours of sleep per night: _____ Number of naps in day: _____ Length of naps in day: _____
Speech or Language difficulties? ◯ YES ◯ NO

OTHER DEVELOPMENTAL HISTORY

Was your child delayed at any of the following?

Respond to Sound ◯ YES ◯ NO
Respond to Visual Stimuli ◯ YES ◯ NO
Hold Head Up ◯ YES ◯ NO
Sit Up ◯ YES ◯ NO
Crawling ◯ YES ◯ NO
Stand Alone ◯ YES ◯ NO
Walk Alone ◯ YES ◯ NO

Has your child fallen from a height? (eg bed, changing table, down stairs)? ◯ YES ◯ NO
List:_____
Recent illness? ◯ YES ◯ NO
Other Falls onto head? ◯ YES ◯ NO
List:_____
Has Your Child Ever Been Involved in a Car Accident? ◯ YES ◯ NO
List:_____
Has your child ever had any broken bones or sprain injuries? ◯ YES ◯ NO
List:_____
Has your child been involved in high impact or contact type sports (eg, Soccer, Football, Gymnastics, Cricket, Martial Arts)? ◯ YES ◯ NO
List:_____
Has Your Child Been Seen on an Emergency Basis or hospitalised? ◯ YES ◯ NO
List:_____

_____

_____

Is your child currently taking medication of any kind? ◯ YES ◯ NO
List:_____
If you could improve one aspect of your child's health, what would it be? _____

_____

_____

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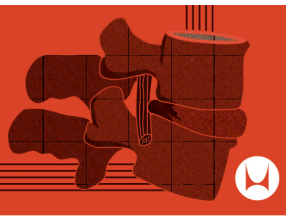

MEDICAL HISTORY:

Has your child experienced any of the following:

ADHD/ADD	Allergies	Anxiety/Depression	Autism/Asperger's
Asthma/Bronchitis	Breathing problems	Back / Neck Pain	Bed Wetting
Blood Noses	Constipation	Colic	Convulsions/seizures/epilepsy
Coughs/Colds	Developmental Delay	Diarrhoea	Difficult Urination
Difficulty Swallowing	Digestive Troubles	Ear Ache/Infections	Ear Infections – 2+
Fatigue	Failure to Thrive	Flaking Scalp	Gas
Hyperactivity	Headache	Hearing Loss	Poor/Excess Weight Gain
Irritability	Meningitis	Stomach Pains	Milk/Lactose Intolerance
Night Pain	Rashes	Vision Loss	Muscle Tone Problems
Reflux	Sinus/Allergies	Skin Rashes	Sleep Issues
Toe Walking	Unusual Movements	Fall - crib/change table	
Fall from play equipment/bike/tree etc.			

For Girls, onset of Menarche (first period): YES NO Age: _____

CHILDHOOD DISEASES

Chicken Pox @ Age: _____ Mumps @ Age: _____ Rubella @ Age: _____
Whooping Cough @ Age: _____ Measles @ Age: _____
Other (List: _____) @ Age: _____

CHIROPRACTIC HISTORY

Has your child had previous Chiropractic care? YES NO
If Yes, what is the name of your previous Chiropractor? : _____
Where are / were they located? : _____
When was the last visit / treatment? : _____
Were X-Rays taken? YES NO
If Yes, when?: ___/___/_____

Was the previous Chiropractor a Gonstead practitioner? YES NO NOT SURE
What were the results of your previous treatment?
Excellent Satisfactory Fair Did Not Help Got Worse

Parental/Guardian Consent for Examination and Treatment of a Minor

I authorise for my child to be appropriately examined and treated for their condition. I understand that there are minor risks associated with Chiropractic Manipulation and that these risks are minimised by a thorough examination and the utilisation of the Gonstead System of Chiropractic. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and agree to pay the fees which have been explained to me at the time this service is rendered.

_____ _____
Child / Patient Name (Printed) Patient / Guardian Signature

Date: ___/___/_____