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? __________

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: ____/____/________

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