CHILD PERSONAL AND FAMILY HISTORY

DATE: ____ / ____ / ____

Childs Name: _____

Preferred Name: _____ **Date of Birth:** _____ **Age:** _____

Mothers Name: _____ **Fathers Name:** _____

Street Address: _____

Suburb: _____ **Post Code:** _____

Telephone: (H) _____ **(W)** _____ **(M)** _____

E-Mail: _____

Private Health Fund: _____

Gender: Male / Female

Has your child received Chiropractic care in the past? Yes / No **Approximate date of last visit?** _____

Who can we thank for recommending you to our practice? _____

Would you like to receive SMS appointment reminders? Yes / No

Do you consent to communication via emails, SMS and social networking sites? Yes / No

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CURRENT HEALTH CONDITION:

What is the main reason for your childs visit today? _____

When did this condition begin? _____

YOUR PREGNANCY:

Did you experience any of the following during your pregnancy?

- ☐ Difficulties conceiving
- ☐ Miscarriages
- ☐ Smoke or drink
- ☐ Emotional upsets
- ☐ Exercise
- ☐ Healthy diet
- ☐ Falls
- ☐ Medications
- ☐ Accidents
- ☐ Morning sickness

BIRTH DETAILS:

Birth details can give vital clues as to potential spinal problems.

Was your child delivered naturally: Yes / No

- ☐ Posterior
- ☐ Breach
- ☐ Induced
- ☐ Forceps
- ☐ Suction
- ☐ Caesarian
- ☐ Premature
- ☐ Term
- ☐ Late

Where any drugs used in birth? _____

Was the birth difficult or long? _____

Do you believe the birth was traumatic for your child? _____

Was your childs head misshapen at birth? _____ **Bruised?** _____

Where there any complications? _____

BIRTH TO SIX MONTHS:

Was / is your baby?

- ☐ Breast fed — For how long? _____ — Right & Left Breast Evenly? _____
- ☐ Formula fed — From what age? _____ — For how long? _____
- ☐ Colicky — Mild / Moderate / Severe
- ☐ Reflux
- ☐ Silent Reflux
- ☐ Sleeping — Poor / Fair / Good / Excellent
- ☐ Daily Bowel Movements — Easily / With Difficulty
- ☐ Irritable / Unsettled

Were / are you concerned about the shape of your baby's head? Yes / No

Any vaccination reactions? _____

OTHER PROBLEMS:

Is / has your child ever experienced any of the following:

☐ Constipation	☐ Diarrhea	☐ Hyperactivity	☐ Attention Difficulties
☐ Social Problems	☐ Concentration Problems	☐ Learning Difficulties	☐ Seem Uncoordinated
☐ Recurrent Colds/Flu	☐ Ear Aches	☐ Ear Infections	☐ Asthma
☐ Lower Back Pain	☐ Mid Back Pain	☐ Neck Pain	☐ Growing Pains
☐ Joint Problems	☐ Headaches	☐ Sinus	☐ Convulsions
☐ Bedwetting			

When did your child roll onto back? _____ **Sit?** _____

Did your child crawl? Yes / No **At what age?** _____

When did your child walk? _____

Has your child been to hospital for any reason? _____

_____

Has your child had any significant falls / accidents? _____

_____

How many courses of antibiotics has your child had in the last 6 months? _____ **During their lifetime?** _____

Has your child had other prescription medication in the last 6 months? _____ **During their lifetime?** _____

How would you describe your child's eating habits? Excellent / Good / Fair / Poor / Terrible

Is there anything else you would like the Chiropractor to know about your child or his / her family?

_____

Thank you for your efforts completing this form, it will enable us to better serve you and your family!