CHILD SPINAL AND POSTURAL EXAMINATION

Dear Parent,

It is our pleasure to welcome you to our clinic. Please complete the following questionnaire.

Your answers will help us determine whether chiropractic can help your child.

Thank You

NAME OF CHILD: _____ D.O.B.: _____ / _____ / _____ Age: _____

PARENTS NAMES: Mother _____ Father _____

ADDRESS: _____

_____

TEL NUMBERS: Home _____ Mobile _____ Work _____

EMAIL ADDRESS: _____

Other Children's Names: _____ D.O.B.:_____ / _____ / _____ Age _____

_____ D.O.B.:_____ / _____ / _____ Age _____

_____ D.O.B.:_____ / _____ / _____ Age _____

_____ D.O.B.:_____ / _____ / _____ Age _____

How did you hear about the Chiropractic Care offered in this clinic for Children?

- ☐ Our Signage
- ☐ Our Website
- ☐ Yellow Pages - ○ *Online* ○ *Book*
- ☐ Internet Search Engine, please specify: _____
- ☐ Another Health Professional, please specify: _____
- ☐ Friend, please specify: _____
- ☐ Family member, please specify: _____
- ☐ Other, please specify: _____

What concerns do you have regarding the health of your child?

_____

_____

_____

_____

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PREGNANCY

During your pregnancy, did you have any of the following?

☐ Difficulties conceiving? ☐ Any miscarriages? ☐ Falls
☐ Emotional upsets ☐ Motor Vehicle Accidents ☐ Healthy diet
☐ High BP ☐ Swollen ankles / hands ☐ Diabetes
☐ Thyroid problems ☐ Anaemia ☐ Abnormal bleeding
☐ Morning sickness ☐ Exercise ☐ Were you hospitalised?
☐ Any other illnesses?_____

_____

During the pregnancy did you use any of the following?

☐ Medication - reason _____ ☐ Tobacco ☐ Alcohol

_____

BIRTH

The birth of your child can give vital clues as to potential spinal problems.

Was your child delivered:

Normally	☐ Yes	☐ No	Breach	☐ Yes	☐ No
Posterior	☐ Yes	☐ No	Caesarian	☐ Yes	☐ No
At Term	☐ Yes	☐ No	Forceps	☐ Yes	☐ No
Premature	☐ Yes	☐ No	Suction / Vacuum	☐ Yes	☐ No
Late	☐ Yes	☐ No	Induced	☐ Yes	☐ No
Fetal Distress	☐ Yes	☐ No	Meconium Staining	☐ Yes	☐ No

Other _____

_____

_____

_____

Birth Weight _____

How long were you in labour? _____ Hours

How long did you "push" for? _____ mins / Hours

_____

Do you believe the birth was traumatic for your child? ☐ Yes ☐ No

Was your childs head mis-shapen at birth? ☐ Yes ☐ No

Bruising? ☐ Yes ☐ No

Drugs used in Birth? _____

Were there any delivery complications? ☐ Yes ☐ No

Details _____

_____

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BIRTH TO SIX MONTHS

Was your child breast fed? ☐ Yes ☐ No For how long?_____ Months / Years

Did your child prefer to feed of a particular breast? ☐ Right ☐ Left

Were there any difficulties feeding? ☐ Yes ☐ No

Was your child formula fed? ☐ Yes ☐ No For how long?_____ Months / Years

Did your child suffer with colic? ☐ Yes ☐ No How bad was it? ☐ Mild ☐ Moderate ☐ Severe

Did your child suffer with reflux? ☐ Yes ☐ No How bad was it? ☐ Mild ☐ Moderate ☐ Severe

Did your child sleep well? _____ ☐ Yes ☐ No

Did your child sleep in a preferred position? ☐ Yes ☐ No

OTHER PROBLEMS

Please indicate by ticking any of the following conditions which your child has experienced in the past:

☐ Headache	☐ Bedwetting	☐ Loss of appetite	☐ Recurring Fevers
☐ Neck Pain	☐ Hyperactivity	☐ Constipation	☐ Seizures
☐ Earaches/Infections	☐ Constant Fatigue	☐ Diarrhoea	☐ Convulsions
☐ Tonsillitis	☐ Poor Co-ordination	☐ Growing Pains	☐ Poor sleep habits
☐ Sinus Pain	☐ Learning Difficulties	☐ Arm/Leg pain	☐ Allergies
☐ Chest Infections	☐ Visual Disorders	☐ Joint pains	☐ Back Pain
☐ Chronic Colds	☐ Asthma	☐ Skin Conditions	☐ Scoliosis
☐ Hip Problems	☐ Poor appetite	☐ Other _____	

_____

_____

_____

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MEDICAL HISTORY

When did your child roll onto their back? _____ Sit_____

How long did your child crawl for? _____ Months When did they start?_____

When did your child walk?_____ Toilet trained?_____

Is your child accident prone? ☐ Yes ☐ No

Has your child had any significant falls? ☐ Yes ☐ No

Has your child been involved in a motor vehicle accident? ☐ Yes ☐ No

Please describe any significant falls or accidents your child has had?

_____

_____

_____

Is your child on medication? ☐ Yes ☐ No What and what for? _____

How many doses of Prescription Medication has your child taken? In the last 6 months _____

During Lifetime _____

How often has your child taken Antibiotics? In the last 6 months _____

During Lifetime _____

Any vaccination reactions? _____

Has your child had any diseases / illnesses? ☐ Yes ☐ No _____

Has your child ever been Hospitalised or had surgery? ☐ Yes ☐ No If yes, please describe:

_____

Has your child ever had any broken bones or sprain injuries? ☐ Yes ☐ No If yes, please describe:

_____

Does your child have any learning difficulties? ☐ Yes ☐ No _____

_____

How would you describe your childs eating habits: _____

Is there anything else you would like the Chiropractor to know about your child or his/her family? ☐ Yes ☐ No

_____

_____

_____

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INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby consent to the performance of chiropractic examinations, adjustments and procedures on my child by the chiropractor named below and/or anyone authorised by the same chiropractor. I further understand and am informed that, as in all health care, there are some slight risks to treatment and do not expect the chiropractor to be able to anticipate or explain all risks and combinations. I choose to rely on the chiropractor to exercise judgement during the course of the procedure which will be in my childs best interest.

This form in no way waives your right to the complete and thorough examination, diagnosis and treatment administered with due care at a level equal to that of any practitioner in our profession.

I have read this form and understand the information it contains. I will ask any questions openly and directly that may come to my mind regarding this information. I have disclosed all relevant information regarding my childs medical history and I understand that treatment will be provided according to the information I have disclosed.

Signature of Parent/Guardian: _____ Name:_____

Chiropractor:_____ Date:_____

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