

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?



PREGNANCY

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Difficulties conceiving? | <input type="checkbox"/> Any miscarriages? | <input type="checkbox"/> Falls |
| <input type="checkbox"/> Emotional upsets | <input type="checkbox"/> Motor Vehicle Accidents | <input type="checkbox"/> Healthy diet |
| <input type="checkbox"/> High BP | <input type="checkbox"/> Swollen ankles / hands | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Anaemia | <input type="checkbox"/> Abnormal bleeding |
| <input type="checkbox"/> Morning sickness | <input type="checkbox"/> Exercise | <input type="checkbox"/> Were you hospitalised? |
| <input type="checkbox"/> 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Breach | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Posterior | <input type="checkbox"/> Yes <input type="checkbox"/> No | Caesarian | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| At Term | <input type="checkbox"/> Yes <input type="checkbox"/> No | Forceps | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Premature | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suction / Vacuum | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Late | <input type="checkbox"/> Yes <input type="checkbox"/> No | Induced | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fetal Distress | <input type="checkbox"/> Yes <input type="checkbox"/> No | Meconium Staining | <input type="checkbox"/> Yes <input type="checkbox"/> 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

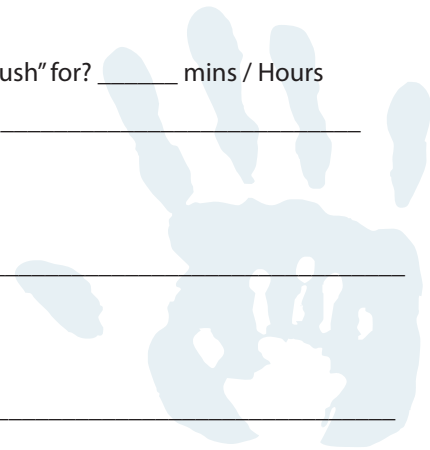
Was your child's head mis-shapen at birth? Yes No

Bruising? Yes No

Drugs used in Birth? _____

Were there any delivery complications? Yes No

Details _____



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

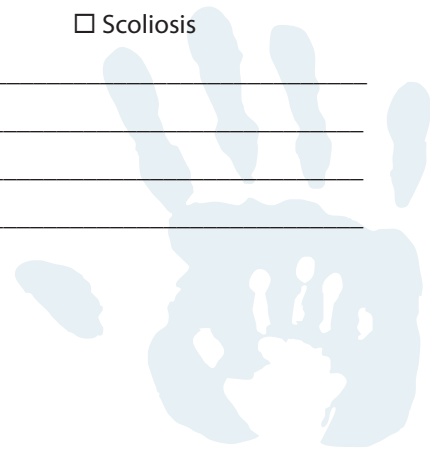
Did your child sleep well? _____ Yes No

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:

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



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 _____

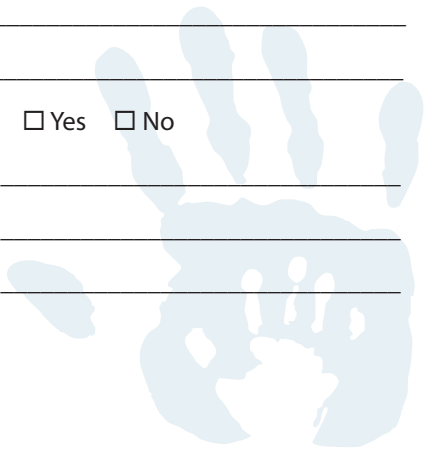
Has your child ever been Hospitalised or had surgery? Yes No If yes, please describe:

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 child's eating habits: _____

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





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 child's 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 child's medical history and I understand that treatment will be provided according to the information I have disclosed.

Signature of Parent/Guardian: _____ Name: _____

Chiropractor: _____ Date: _____

