CONFIDENTIAL FIRST VISIT INFORMATION CHILD 0-12 YEARS

ABOUT YOU Chiropractic

PERSONAL INFORMATION

Name: Date of Birth: ☐ Male ☐ Female

Parents Names:

Address: Postcode:

Phone: Mobile Home Work *(best number to contact you on:* M☐ W☐ H☐ *)*

Email (parent):

Siblings (names and ages):

Interests/ hobbies:

Emergency contact name and number:

Relationship to child:

Any previous chiropractic Care? ☐ Yes ☐ No If yes: Where When

Who may we thank for referring you?

HEALTH CONCERNS

List your child's health concerns in order of priority	When did this start? How long has this been an issue?	Is this getting worse, better, unsure	Have they experienced this health concern before? If yes when?
1.			
2.			
3.			
4.			

Do you feel your child is developing and reaching their milestones at the same rate as their peers? ☐ Yes ☐ No

If no please explain? *Please click on line below if filling out electronically.*

MEDICAL HISTORY

Has your child ever been hospitalised? ☐ Yes ☐ No Had any surgery? ☐ Yes ☐ No

Broken bones? ☐ Yes ☐ No Significant falls / accidents? ☐ Yes ☐ No

Does your child ever bang their head repeatedly? ☐ Yes ☐ No

Who is your child's GP: and /or Paediatrician?

How many courses of antibiotics has your child had: In the past 6 months? During their lifetime?

Has your child had other prescription medication?

In the past 6 months? During their lifetime?

What vitamin and mineral supplements does your child have?

Any family history of medical problems? *Please click on line below if filling out electronically.*

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

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MOTHER'S PREGNANCY HISTORY OF THIS CHILD

Did you have any: *(please tick any of the following that apply to you)*

☐ Difficulties conceiving	☐ Vaginal Bleeding	☐ Any falls	☐ Gestational diabetes	☐ Swelling
☐ Hospitalisations	☐ Trauma	☐ High stress	☐ Pre-eclampsia	☐ Protein in urine
☐ Ultrasounds	☐ Motor accidents	☐ High anxiety	☐ Previous c-section	☐ Vaccines
☐ Morning sickness	☐ Amniocentesis / CVS	☐ Heamorroids	☐ High blood pressure	☐ Recreational drugs
☐ Miscarriages	☐ Exercise	☐ Fainting	☐ Depression	☐ Alcohol / smoking

Were you aware of any health concerns in this pregnancy? ☐ Yes ☐ No

Did mother have chiropractic care during this pregnancy? ☐ Yes ☐ No

What other health practitioners did you consult during this pregnancy:

What number pregnancy was this? Was conception: ☐ natural *or* ☐ assisted?

Is there anything else you would like us to know about you and your pregnancy? *Please click on line below if filling out electronically.*

BIRTH DETAILS CAN GIVE VITAL CLUES AS TO POTENTIAL SPINAL PROBLEMS

Gestational age of child when born:

Child Birth Carers *(please tick)*: ☐ Doula ☐ Midwife ☐ OB/GYN ☐ Other:

Where did you birth: ☐ Home: ☐ Birth Centre: ☐ Hospital: ☐ Other:

Was you child delivered normally? ☐ Yes ☐ No

Was the birth difficult / long? ☐ Yes ☐ No Length of labour:

Do you believe the birth was traumatic for your child?

Any interventions used in the birth? ☐ Yes ☐ No

Please tick if Yes:

☐ Induction	☐ Forceps	☐ Epidural	☐ Prosten Gel
☐ Breaking of waters	☐ Episiotomy	☐ Gas	☐ C-section
☐ Ventuse / Vacuum extraction	☐ Physical force / Pulling	☐ Syntocinon	☐ Other

What was baby's presentation at delivery:

☐ Head down	☐ Frank Breech	☐ Brow	☐ Other
☐ Footling Breech	☐ Posterior	☐ Facial	

Apgar score: Birth Weight: Length: Head Circumference:

Was your child's head misshapen at birth? ☐ Yes ☐ No Bruised? ☐ Yes ☐ No

Were there any complications? ☐ Yes ☐ No

Resuscitation: ☐ Yes ☐ No how long? Incubation: ☐ Yes ☐ No how long?

Separation from mum: ☐ Yes ☐ No how long?

Was there any medical intervention needed for mum post birth/s. ie: stitches, transfusion?

If yes please describe:

Was there any medical intervention needed for baby/s post birth? ie: Neonatal intensive care, comp feeding?

Any history of Post-Natal Depression? *Please click on line below if filling out electronically.*

BIRTH TO SIX MONTHS

Did you breast feed? ☐ Yes ☐ No If so how long? Difficulties breast feeding: ☐ Yes ☐ No

Right and left breast evenly? ☐ Yes ☐ No

Formula fed: ☐ Yes ☐ No From what age? For how Long?

Was your baby 'Colicky'? ☐ Yes ☐ No ☐ Mild ☐ Moderate ☐ Severe

Does / did your baby have reflux? ☐ Yes ☐ No 'Silent' reflux? ☐ Yes ☐ No

How does your baby sleep? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Does your baby have a preferred sleeping position? ☐ Yes ☐ No

Does your baby regularly move his /her bowels? How often Easily: ☐ Yes ☐ No

Was / is your baby irritable / unsettled? ☐ Yes ☐ No

More rigid or floppy in her / his posture than you would expect?

Are you concerned about the shape of your baby's head? ☐ Yes ☐ No

Any reactions to vaccines? ☐ Yes ☐ No *Please click on line below if filling out electronically.*

DEVELOPMENTAL HISTORY

When did your child roll? Sit? Pull to stand?

Did your child crawl properly? ☐ Yes ☐ No At what age:

When did your child walk?

Does your child have any speech difficulties?

SCHOOL HISTORY (AGE 5-12)

Grade at school: School attending?

Does your child have any difficulties with the following?

☐ Reading ☐ Handwriting ☐ Co-ordination ☐ Sitting still
☐ Maths ☐ Physical activity ☐ Copying from the board ☐ Listening skills

Does your child have a learning or developmental diagnosis? *Please click on line below if filling out electronically.*

GENERAL HEALTH

Is or has your child experienced any of the following? *(please tick)*

☐ Allergies
☐ Anxiety
☐ Asthma
☐ Attention difficulties
☐ Behavioural problems
☐ Bet wetting
☐ Chronic fatigue
☐ Clicky hips
☐ Concentration problems
☐ Constipation
☐ Convulsions / seizures
☐ Dehydration
☐ Diagnosed ADHD
☐ Diagnosed Autism/ Asperger's
☐ Diarrhoea
☐ Ear aches
☐ Ear infections
☐ Exposure to smokers
☐ Flat feet
☐ Food Intolerance
☐ Frequent falls/ accidents
☐ Grief in past 12 months
☐ Growing pains
☐ Headaches
☐ Hyperactivity
☐ Irritability
☐ Joint problems
☐ Learning difficulties
☐ Lower back pain
☐ Middle back pain
☐ Moods / reactions
☐ Neck pain
☐ Night terrors
☐ Perfectionism
☐ Poor appetite
☐ Recurrent chest infections
☐ Recurrent colds/ flus
☐ Recurrent throat infections
☐ Recurrent tonsillitis
☐ Scoliosis
☐ Seems uncoordinated
☐ Sinus
☐ Sleep problems
☐ Social problems
☐ Stomach sleeper
☐ Tongue tie

GENERAL HEALTH (CONTINUED)

Is your child a good sleeper: ☐ Yes ☐ No If no please detail: *Please click on line below if filling out electronically.*

Tick the phrase that most represent your child's reason for care:

☐ Wellness ☐ Prevention ☐ Feel Good ☐ Symptom relief

Rate your child's well being today: *Please click on check box if filling out electronically*

(Poor)	1	2	3	4	5	6	7	8	9	10	*(Excellent)*
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

INFORMED CONSENT

Chiropractic care is well recognised for being an extremely safe and effective form of care for many conditions.

Chiropractors complete a 5 year university degree and are registered health care professionals; regulated by the Australian Health Professionals Registration Board. Chiropractors are required to adhere to extensive continuing educational requirements to maintain their professional registration.

As with all healthcare, there is a possibility of a worsening of the condition. An extensive review of literature for adverse effects due to chiropractic care administered to children and infants by a registered chiropractor found no deaths in 40 years. A review of the safety of spinal manipulative therapy by various health professionals found 15 serious adverse events, 7 were administered by chiropractors. In the majority of cases pre-existing pathology was later identified. (1) No serious adverse event has been reported in the literature since 1992. One child per 100-200 may suffer a mild adverse event including increased irritability or soreness lasting less than 24 hours. (2) Approximately 30 million children are adjusted by chiropractors in a year in the USA alone.

I hereby give consent for my child (name):

to receive chiropractic care from a registered Chiropractor and agree to undergo examinations to monitor their progress including xrays when and if required.

Parents / Guardians Name:

Chiropractors' name:

Signature:

Signature:

Date:

Date:

1. Todd.A et al Adverse events due to chiropractic and other manual therapies for infants and children: A review of the literature. JMPT. 2015: 38: 699-712

2. Doyle M. Is Chiropractic pediatric care safe? A best evidence topic. Clinical Chiropractic 2011: 14 (3): 97-105

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