CONFIDENTIAL CHILD PATIENT HISTORY FORM 0 - 3 YEARS

First Name:	Surname:	Age	Date of Birth: / /		
Street:					
Suburb:	State:	Postcode:			
Parent's Name:		(PH):		(M):	
Parent's email:					
Has child been to a chiropractor before? **Yes / No**	When was the last treatment?				
Who referred you to this clinic?	Private Health Fund:				
What is the main reason for attending this chiropractic clinic?					
Has your child had any form of treatment for this complaint?					
Immunised? **Yes / No**	Allergies?	Problems during pregnancy?			
Gestational period? **/40**	Baby's presentation at birth? **Normal / Posterior / Breech / Transverse**				
Head shape at birth? **Normal / Asymmetric**	Wry neck at birth? **Yes / No**				
Problems requiring treatment at birth?	Child respirated at birth? **Yes / No**				
Type of delivery? **Normal / Breech / Forceps / Caesarean / Suction**					
Labour **Spontaneous / Induced**	Inducement reason?				
Labour complications/concerns?	Duration of labour?	Apgar ? 1 min /10 5 min /10			

Birth Weight?	**Kg**	Current weight?	**Kg**	Birth Length?	**cm**	Head circumference?	**Cm**

Has your child ever been to hospital, had any major bumps/falls or surgery? Please give details:

When was their last visit to the Dr? Please give details:

……...

Developmental concerns? **Yes / No**	Number & age of siblings?		
Feeding at discharge? **Breast / Bottle**	Difficulties feeding? **Yes / No**	Breastfed? **Months**	
Still giving formula? **Yes / No**	Type of formula?	Lactose intolerant? **Yes / No**	
Colicky? **Yes / No**	Introduction to solids? **months**	Age crawling?	Age Walking?

Hand dominance: **Left / Right**	Foot dominance: **Left / Right**	Eye dominance: **Left / Right**	Ear dominance: **Left / Right**

GENERAL HEALTH: Please Circle 0_____5_____10
Poor excellent

Appetite: **GOOD / FAIR** Activity and energy levels: **GOOD / FAIR** Crying patterns: **GOOD / FAIR**

Sleeping position? Sleep duration at night: Sleep duration during day:

Faeces Colour: Consistency: Frequency : Straining: **Yes / No**

Past illness? **Yes / No** Present illness? **Yes / No** Is your baby sick? **Yes / No**

Have you noticed your baby has problems with any of the following: Please circle:

Headaches / Fever / Irritability
Hearing / Ear problems / Infections
Eye problems
Nose / Sinus / Hayfever / Allergies
New or recurrent cough
Mouth problems / Throat Infections / Teething
Asthma / Respiratory infections / Breathing problems
Bones or Joint pain / Growth and development / Clicky hips
Discomfort Nursing on one side / Head held on one side
Irritability changing clothes or nappy
Muscle Control / Lack of muscle tone / Balance and Co-ordination
Skin conditions / Rash/Cradle cap
Lumps / Swelling / Bruising
Vomitting / Digesting food / Colic
Diarrhoea / Constipation / Reflux
Gastrointestinal / Abdominal discomfort
Genital Problems
Urinary Problems / Bedwetting
Heart Problems
Psychological / Behavioural / Attention
Seizures
Night mares/night terrors

Is your child taking any medication or nutritional supplements? Please list:

……..……. ……..……..……. ……..…….

Has your child taken long-term medication in the past? Please list:

…….

Has your child fractured, broken or dislocated any part of their body? Please give details:

…….

Family History? Please circle

Stroke Cancer Diabetes Heart Problems Migraine

PATIENT CONSENT FORM – CHILD

Changes to the law now require all practitioners who apply manual therapy to the spine to warn patients of material risks.

Published cases of serious adverse events in infants and children receiving chiropractic therapy are rare (23). Chiropractors are trained to modify their treatment to suit the age and presentation of the child and special styles of very gentle treatment are used for babies and young children. A thorough history and examination is performed to minimize any risk involved with the care provided and to determine if co-management or referral to another health professional is warranted.

The most common complaints in infants and children after chiropractic care are stiffness or soreness, and restlessness or increased crying. These effects, if they occur, can be expected to last less than 24 hours following treatment.

If you have any questions related to the treatment your child is to receive, please speak to the chiropractor.

I am the parent or legal guardian of (child's name) _____

I understand and have an opportunity to discuss the above information with the chiropractor and give my consent to examination and treatment.

Parent or legal guardian's signature_____Date:_____