Child Health Questionnaire 0-12 yrs

Life Chiropractic & Wellness

Name: Title:____ First name:_____ Surname:_____

Gender: M / F Date of birth:_____

Parent/Guardian: First name:_____ Surname:_____

Address:_____ Suburb:_____ Postcode:_____

Contact numbers: H:_____ W:_____ M:_____

Email:_____ Occupation:_____

Private health fund:_____

Have you been to a chiropractor before? Yes/No. Name:_____ When:_____

How did you hear about us? Signage Internet Facebook Website

Family/Friend: Name:_____ Other:_____

Current health

Major symptom/concern:_____

How long have you suffered this complaint?:_____ Triggered by?_____

Describe pain: Sharp □ Dull □ Burning □ Constant □ Intermittent □

Are the symptoms: Getting worse □Staying the same □ Getting better □. Comes and goes □

What brings on the problem or make it worse:_____

What relieves the problem or makes it better:_____

Do you have any concerns about the following?

Sleep problems □ Head shape asymmetry □ Poor posture □ Learning difficulties □

Muscle tone □ Moods/reactions □ Coordination/balance □ Headaches. □

Crawling/walking □ Digestion/feeding □ Achieve milestones □ Hip/Knee/Leg/Foot □

Back/neck pain □ Recurrent infections □ Growing pain □ Visual disorder □

Allergies □ Poor neck movement □ Asthma □ Seizures/convulsions □

Joint pain □ Fatigue □ Scoliosis □ Sinus problems □

Have you seen anyone else about this problem? Yes/ No GP □ Chiro □ Physio □

Other Details:_____

Do you take any medications?: _____

Do you have any other problems/concerns:_____

Pregnancy

Did the mother have any difficulties during pregnancy? Yes No

Details:_____

Birth
The details of your Childs birth can give us vital clues to potential spinal problems. Please describe your child's birth including medical interventions:

_____

_____

Your child was delivered: Please circle

Normally □ Breech □
Posterior □ Premature □
At term □ Caesarian □
Late □ Forceps □
Chemical induced □ Suction/ Vacuum □

Birth weight:_____ Apgar scores: _____ Immediately _____ 3 Min

How long was labour? _____ Hrs How long did you "push" for? _____ Min/Hrs

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

Did your child have: Facial bruising □ Odd Shaped head □ Swelling □ Jaundice □

Birth to six months

Was your child breasted Yes No For how long?_____

Was your child formula fed Yes No For how long?_____Type_____

Did your child suffer colic Yes No Mild Moderate Severe

Did your child suffer reflux Yes No Mild Moderate Severe

Was your child a: Very poor sleeper □ Poor sleeper □ Average sleeper □ Good sleeper □ Very good sleeper □

Did your child hold hear/his head in any particular way?_____

Developmental

Did your child like tummy time? Yes No

Did your child reach milestones at similar rate to their peers? Yes No

When did your child start sitting on their own? _____ Months

When did your child starts crawling?_____ Months, Walking_____Months

How long did your child crawl for? _____ Months

Medical history

Is your child accident prone? Yes No Has your child had any significant falls? Yes No

Please describe any falls or accidents your child has had.

_____

_____

Is your child on any medication? Yes No Details:_____

Vaccination history:_____

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

Have your child been hospitalised or has any surgeries? Yes No Details:_____

_____

Has your child had any broken bones or sprains? Yes No Details:_____

Has your child been assessed for presence of scoliosis? Yes No

Has your child had a learning disorder? Yes No

How many times has your child been on antibiotics? In last 6 Months_____During Lifetime_____

How many other prescription medication taken? In last 6 months_____ During Lifetime_____

Is there any other information or details you think we should know? _____

_____

_____

Cancellation and fee policy

All fees is to be paid on the day of consultation. For your convenience we have hicaps and eftpos facilities available for you to be able to claim your private health fund rebate on the spot.

Life Chiropractic and wellness has a 24-hr cancellation policy. We require a minimum notice of 24 hours to cancel or reschedule appointments to avoid a $20 cancellation fee. This includes any missed appointments.

I,_____ acknowledge the a above cancellation policy and give Life Chiropractic and wellness permission to charge me a cancellation or missed appointment fee as appropriate.

Signed:_____ Date:_____[1]