LIFETIMECHIRO

New Child Questionnaire

Private & Confidential

Welcome. Some of the following information is legally required, the rest assists in uncovering the stressors affecting your child's spine and nerve system and heir healing potential. It's ok for children to be healthy and happy and still benefit from chiropractic.

Date _____

Personal Details

Name _____
First Surname Preferred Name

Date of Birth _____ Age _____

Address _____

Suburb _____ Postcode _____ State _____

Parent's Names _____

Contact Email _____

Contact Mobile _____

How did you hear about us? _____

Child's GP _____

Health History

Main concern for today's visit _____

Did any of the following occur with your child's pregnancy or birth?

		Pregnancy
Y	N	Intake of smoke, alcohol, drugs
Y	N	Poor diet
Y	N	Excessive morning sickness
Y	N	Falls or injuries
Y	N	Suffer any illness/diabetes/hypertension
		Birth Itself
Y	N	Premature delivery
Y	N	Labour Induced
Y	N	Hospital Birth
Y	N	Home Birth
Y	N	Very fast birth
Y	N	Long or difficult delivery
Y	N	Forceps or ventouse
Y	N	Caesarean section
Y	N	Breech / unusual presentation
Y	N	Mother given drugs during delivery
		Since Birth
Y	N	Preference for feeding side
Y	N	Sleeping all the time
Y	N	Not sleeping well, difficult to settle
Y	N	Head banging or rocking
Y	N	Recurrent sickness (ears, stomach etc)
Y	N	Significant accidents (breaks, sprains)
Y	N	Surgery
Y	N	Slow to meet milestones
Y	N	Given any drugs (antibiotics, pamil)

		Does your child have trouble with….
Y	N	Teeth, eyes, ears, throat infections
Y	N	Speech, concentration
Y	N	Coughs, colds, asthma, fevers
Y	N	Colic, burping, reflux, bloating, gas
Y	N	Bowel movements (too many / too few)
Y	N	Urination, bedwetting
Y	N	Social behaviour
Y	N	Heart, circulatory, pins and needles, numbness
Y	N	Skin rashes, itchiness, hair falling out
Y	N	Bruises easily, tired all the time
Y	N	Muscle weakness in-coordination, fall over, bump into things
Y	N	Headaches, neck pain, joint pain, back pain
		General Lifestyle
Y	N	Take vitamin / mineral supplements daily
Y	N	Eat fruit and a variety of vegetables and meat
Y	N	Have any allergies that you are aware of
Y	N	Eat junk food / takeaways
Y	N	Play any sports, recreational activities
Y	N	Watch more than 15 hours of tv a week
Y	N	Vaccinated
Y	N	Have stress in their life. Home, school, sibling rivalry
Y	N	Have friends, socialise comfortably

Anything else we should know about?

_____

_____

_____

APGAR Score _____ Birth Weight _____ Birth Length _____

Breast _____ Bottle _____ Solids _____

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CHILD CONSENT FORM

Chiropractic Care, when performed by a qualified Chiropractor has been found to be both an effective and safe form of care for many health conditions. There are, however, risks associated with any treatment no matter how small, that you need to be informed of and we ask that you read the following carefully:

I understand there are very minimal risks resulting from treatment, such as but not limited to: muscle and joint soreness, sprain, muscle strain, disc injury, nerve irritation or damage.

I understand in extremely rare cases, some treatments to the neck may result in injury to blood vessels and give rise to stroke or stroke like symptoms. (approximately 1 in 5.85 million neck adjustment.)

I understand that results are not guaranteed and that consent can be withdrawn at any time.

I give consent, by signing below, to cover the entire course of treatment for my presenting complaint(s), and for any other future condition(s) for which I seek treatment from the below named Chiropractor and any of the registered Chiropractors practicing at Lifetime Wellness at Kenmore.

In the case of chiropractic services being rendered to a minor, or a patient who is recognised to have diminished intellectual capacity, this consent is to be signed by either a parent or legal guardian, this fact being appropriately noted below. I have read or have had read to me the above consent and I have also had an opportunity to ask questions about this consent.

I _____ as the legal guardian of the above-mentioned child consent to

_____ receiving a chiropractic examination and chiropractic adjustments.

_____	_____	___ / ___ / ___
Parent's Name (PRINTED)	Parent's Signature	Date
_____	_____	___ / ___ / ___
Chiropractor's Name (PRINTED)	Chiropractor's Signature	Date

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