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 to determine whether chiropractic can help your child. Please note this is a postural and spinal examination only. No chiropractic treatment will be rendered. If treatment is required you will be advised of this and an appointment can be made for a later date.

Thank You!

Name of Child:_____M___F___D.O.B._____/____/___Age:_____

Parents Names: Father_____ Mother_____

Address:_____ Postcode _____

Contact Phone Numbers:

Home_____Mobile_____Work_____

Email_____

Other Children's Names:-

_____D.O.B._____/_____/_____Age_____

_____D.O.B._____/_____/_____Age_____

_____D.O.B._____/_____/_____Age_____

How did you hear of the postural and spinal examination offered in this clinic? (please circle)
Family member Staff Member Friend Other

Do you have private health insurance for chiropractic? Yes/No/Unsure

Name of Health Fund:_____

What concerns do you have regarding the health of your child?

_____
_____
_____
_____
_____

BIRTH

The birth of your child can give vital clues as to potential spinal problems. Please answer the following questions very carefully.

Was your child delivered:

Normally	Yes/No	Breech	Yes/No
Posterior	Yes/No	Premature	Yes/No
At Term	Yes/No	Caesarian	Yes/No
Late	Yes/No	Forceps	Yes/No
Chemically Induced	Yes/No	Suction/Vacuum	Yes/No

Other_____

Birth Weight:_____ Apgar Score_____ _____

How long were you in labour?___Hours How Long did your "push"for?___Mins/Hours

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

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

Were there any delivery complications? Yes/No

Details_____

BIRTH TO SIX MONTHS

Was your child breast fed? Yes/No For How Long?_____

Was your child formula fed? Yes/No For How Long?_____

Did your child suffer with colic? Yes/No If yes, How bad was it? Mild Moderate Severe

Did your child suffer with reflux? Yes/No If yes, how bad was it? Mild Moderate Severe

Would you say your child was a :

Very poor sleeper Poor Sleeper Average Sleeper Good Sleeper Very Good Sleeper

OTHER PROBLEMS

Please indicate by circling any of the following conditions which your child has experienced in the past:-

Headache	Allergies	Neck Pain
Back Pain	Constipation/Diarrhea	Sinus Pain
Earaches/Infections	Recurrent Tonsillitis	Bedwetting
Recurrent Chest infections	Growing pains	Hyperactivity
Loss of appetite	Poor sleeping habits	Visual disorders
Constant Fatigue	Arm/Leg Pain	Poor co-ordination
Learning Difficulties	Recurrent stomach aches	Digestive disorders
Scoliosis	Fever	Convulsions
Joint Pains	Asthma	Travel sickness
Night Terrors	Seizures	Chronic colds
Recurring fevers	Hip problems	

MEDICAL HISTORY

How long did your child crawl for?__months
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:
_____

Has your child ever been involved in a motor vehicle accident? Yes/No

Is your child on medication? Yes/No
(If yes)Please List Medications: _____

VaccinationHistory?_____

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

_____

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

Has your child had a learning disorder? Yes/No

How many times has your child taken antibiotics?

In Last Six Months_____During Lifetime____

How many doses of other Prescription Medication has your child taken?

In Last Six Month_____During Lifetime_____

PREVIOUS CHIROPRACTIC CARE

Has your child had previous chiropractic care? Yes/No

Date of last care____/____/____Name of Chiropractor_____

Location of Clinic_____Were X-Rays taken Yes/No

LifetimeWellness
CHIROPRACTIC & WELLNESS SERVICES
WELLNESS ...A Lifestyle for a Lifetime

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 for X-rays to be taken today if required.

Females only: For X-ray purposes
Are you pregnant or likely to be pregnant? Yes No
If yes how many weeks? _____

Please sign_____

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 Family Chiropractic Wellness Centres 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.

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

LIFETIME WELLNESS

876 Moggill Road Kenmore Qld 4069 Ph. (07) 3878 1553 Fax (07) 3878 6333
Web site www.kenmorechiropractic.com.au