Bangalore Chiropractic
& WELLNESS CLINICS™
NATURAL HEALTHCARE SOLUTIONS

CHILDREN'S SCREENING

PATIENT ID:_____

Patient Information

Name: _____ Parent's Names: _____
Given Names Surname

Address:_____

_____

Home/Mobile: _____E-mail: _____

Standard: _____Date of Birth: _____ (dd/mm/yyyy)

Age: _____ ☐ Male ☐ Female

Language(s) spoken: _____

Who recommended you to this Clinic? _____

Health History

Please list all accidents, or falls that may have affected your child's spine: _____

_____

Please check any danger signals that your child may have:

- ☐ Headaches
- ☐ Pain in Arms or Legs
- ☐ Pain between Shoulders
- ☐ Painful Joints
- ☐ Coordination Problems
- ☐ Dizziness/Drowsy
- ☐ Fussy baby (colic or reflux)
- ☐ Asthma
- ☐ Stiffness or pain of the Neck
- ☐ Bed Wetting
- ☐ Numbness/Tingling in Hands/Feet
- ☐ Lower Back Ache
- ☐ Recurrent Infections (ear/tonsils)
- ☐ Allergies
- ☐ Difficulty sleeping
- ☐ ADHD

Briefly describe your child's current symptoms: _____

_____

_____

When did your child's symptoms begin? _____
Has your child has similar symptoms in the past? _____

Is your child taking any medication, if yes – what for? _____

Previous treatment by which doctor: _____

What surgery (if any) has your child had? _____

What is your child's preferred sleeping position? _____

Chiropractic care is recognised as being extremely safe and an effective method of care. As with all health care procedures it is acknowledged that there are risks. I hereby offer my consent to the proposed chiropractic care by the Chiropractors' of this clinic. I understand that I can withdraw consent at any time.

PARENT SIGNATURE: _____ DATE: _____