Westernport Innate Chiropractic

Child Health History

Childs Full name:			**Date:**
Parents names:			
Address: Street	Suburb	State	P/Code
Home phone:		**Work phone:**	
Mobile:		**Email address:**	
Date of birth:		**Age:**	

Whom may we thank for referring you? _____

What brings you and your child in to see us today?

☐ My child is here for a general health evaluation. ☐ My child is suffering from a particular health problem/symptom.

Please describe your child's complaint/s, including when and how they started:

_____

_____

_____

_____

What treatment and tests has your child received for his/her problems so far?

_____

_____

Has your child ever seen a chiropractor? __ Y __ N Who? _____

Who is your child's pediatrician? Name: _____ **Location:** _____

Was your child delivered…… vaginally or…….. by caesarian ?

Yes/ No Were forceps or vacuum extraction used? _____

Yes/ No Was there tugging on your babies neck during the birth process? _____

Yes/ No Is (or was) your child breast fed? If yes, how long was he/she breastfed? _____

Yes/ No Is (or was) your child formula fed? Which formula? _____

Yes/ No Has your child had any falls or trauma? _____

Yes/ No Has your child ever been in a car accident? _____

Yes/ No Has your child ever had any antibiotics? _____

Yes/ No Has your child had any other illnesses? _____

Yes/ No Has your child taken any medication in the past? _____

Yes/ No Has your child been vaccinated? _____

Yes/ No Has your child had any surgeries or hospital visits? _____

Yes/ No Does your child release their bowels every day? _____

What does your child normally eat for Breakfast? _____

_____

What does your child normally eat for Lunch? _____

_____

What does your child normally eat for Dinner? _____

_____

What does your child normally eat for Snacks? _____

_____

Is your child taking any over the counter or prescription medication? _____

Is your child taking any vitamins/supplements? _____

Tick any of the following that your child has had or does have:

☐ **Allergy/sinus**	☐ **Arthritis**	☐ **Asthma**	☐ **Colic**	☐ **Learning Difficulties**	☐ **Depression**
☐ **Diabetes**	☐ **Eczema**	☐ **Ear Infections**	☐ **Reflux**	☐ **Back / Neck Pain**	☐**Torticollis**
☐ **Constipation**	☐ **Nervousness**	☐ **Headaches/ Migraines**	☐ **ADD/ ADHD**	☐ **Bedwetting**	☐ **Frequent Colds/Flu**

Other (please explain) _____

I, the undersigned, being the parent/guardian of _____, certify that the above information is correct. I hereby consent to the performance of a complete chiropractic examination and treatment by any registered chiropractor engaged by Westernport Innate Chiropractic. I have been informed of all the risks associated with the recommended treatment in terms that I have understood and have also been given the opportunity to ask questions. I understand that results are not guaranteed and that the chiropractor will always act in the patient's best interests based on the facts known at that time. I acknowledge, being the parent/guardian that any fee for services rendered are due at the time of the service and cannot be deferred to a later date. I understand the above and consent to chiropractic treatment for the patient's present condition and any future condition(s). I also understand that I can withdraw my consent at any time.

_____

Print name of parent or legal guardian

_____ _____/_____/_____

Signature of Parent/Guardian **Date**