



Primary Age Child Health History

Childs Full name:			
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? _____

Why did you bring 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 If so, whom? _____

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

<input type="checkbox"/> Allergy/sinus	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Asthma	<input type="checkbox"/> Colic	<input type="checkbox"/> Learning Difficulties	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eczema	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Reflux	<input type="checkbox"/> Back / Neck Pain	<input type="checkbox"/> Torticollis
<input type="checkbox"/> Constipation	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Headaches/ Migraines	<input type="checkbox"/> ADD/ ADHD	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Frequent Colds/Flu

Other (please explain) _____

So we can help form an idea of how we can best help your child, it is important that we get a complete picture of your child's health history.

Was your child delivered by caesarian? _____

Were forceps or vacuum extraction used during birth? _____

Was there tugging on your babies neck during the birth process? _____

Has your child been vaccinated? _____

Has your child had any falls or trauma? _____

Has your child ever been in a car accident? _____

Has your child ever had any antibiotics? _____

Has your child had any other illnesses? _____

Has your child taken any medication in the past? _____

Has your child had any surgeries or hospital visits? _____

Does your child release their bowels every day? _____

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

Is your child taking any vitamins/supplements? _____

Please grade the present levels of stress using - High, Medium or Low:

At school	At home:	At play:
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Using Good, Average or Poor please describe your child's:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
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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