Sanctuary Lakes Chiropractic

Paediatric Screening Form

The completion of this form is a sensible first step prior to experiencing the many benefits associated with chiropractic. This form has been designed to assist with delivering the most appropriate chiropractic treatment and/or identifying any possible risk factors to your health and safety to provide appropriate care and advice.

ABOUT YOUR CHILD

Child's Name:_____

Child's Birth Date:_____ Age:_____

School Attended:_____

Referred By:_____

FAMILY INFORMATION

Parent's Name:_____

Phone: (H)_____(W)_____(M)_____

Address:_____

Please list any other children (including birth dates):

_____

_____

How did you hear about us? Referral____ Yellow Pages____ Signage____ Other_____

YOUR CHILD'S HEALTH HISTORY

Reason for today's visit:_____

Type of birth: Normal Vaginal ____ Caesarean ____ Home ____

Vacuum Extraction ____ Forceps ____ Hospital ____

Problems during pregnancy, labour, delivery :_____

Congenital anomalies / defects:_____

Vaccination history:_____

Is your child uncomfortable sleeping in any particular position?_____

Number of hours your child sleeps per night_____ Quality of sleep: GOOD----------POOR

Does your child feed better from one side?_____

Last visit to GP:_____ Purpose:_____

According to the US National Safety Council, approximately 50% of all children have fallen from a high place during their first year of life (eg. Bed, change table, stairs) Is this the case with your child?_____

As the legal guardian, I hereby give my permission for this clinic and its doctor to administer care as they so deem necessary to this child.

…… Date: ……

Parent or Guardian Signature

THE CHILD'S SYMPTOMS IN THE LAST 12 MONTHS:

___ Low Back Pain	___ Digestive Troubles	___Headaches
___Sleeping Disorder	___Ear/Throat Infection	___Fatigue
___Hyperactivity	___Meningitis	___Constipation
___Milk/Lactose Intolerance	___Loss of Hearing	___Neck Pain
___Asthma	___Allergies	___Cold/Flu
___Breathing Problems	___Irritability	___Blood Noses
___Diarrhoea	___Bed Wetting	___Colic
___Sinus Problems	Other:_____	

THE CHILD'S CURRENT CONDITION

Is your child accident prone?	Y	N
Has the child had any falls down steps?	Y	N
Has your child ever fallen from heights of over 2 feet?	Y	N
Has your child ever been involved in a motor vehicle accident?	Y	N
Has your child ever been hospitalised or had surgery?	Y	N
Has your child ever had any broken bones or sprain injuries?	Y	N
Has your child a learning disorder?	Y	N
Has your child poor posture?	Y	N
Is your child on medication of any kind?	Y	N

If yes, please specify:_____

Has your child had a spinal curvature (scoliosis) examined by a qualified Practitioner? Y N

Does your child show signs of nervousness, twitching, excessive talking to themselves? Y N

If you could improve one aspect of your child's health or behaviour, what would it be?

_____

Relevant Family History:_____

Please note that any and all information, written or otherwise, that you give us is strictly confidential and is so treated by the entire staff. No information or records will be released to any person, health fund, insurance company or any doctor without the written permission of the patient.

I believe the information above is correct to the best of my knowledge.

…… Date: ……

Parent or Guardian Signature