CAPACITY HEALTH CHILD PATIENT FORM

C H I R O P R A C T I C • H E A L T H C O A C H I N G

SURNAME .... GIVEN NAMES .... DATE / /

WHO MAY WE THANK FOR REFERRING YOU? ....

YOUR FULL ADDRESS ....

.... POST CODE ....

HOME PHONE .... MOBILE PHONE ....

EMAIL .... IF YOU DO NOT WISH TO BE CONTACTED BY EMAIL, PLEASE TICK BOX ☐

AGE .... BIRTHDATE / / SEX MALE ☐ FEMALE ☐ NO. SIBLINGS ....

PARENT / GUARDIAN NAME (S) ....

EMERGENCY CONTACT: NAME .... RELATIONSHIP .... CONTACT No. ....

HAS YOU CHILD EVER RECIEVED CHIROPRACTIC CARE? **YES / NO**

IF YES, PREVIOUS DC'S NAME AND LAST VISIT ....

AUTHORIZATION FOR CARE OF A MINOR (UNDER 18 YEARS)

PARENT / GUARDIAN (S) NAMES ....

CONTACT NUMBER(S) ....

I hereby authorize consent to the chiropractic evaluation of my child. NAME ....

PARENT / GUARDIAN SIGNATURE ....

DATE ....

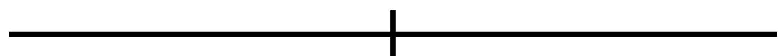
☐ *If there are no current concerns and this assessment is to ensure optimum health, function and wellness tick this box*

PRESENT HEALTH COMPLAINTS / CONCERNS

....

....

....



If pain is involved, rank it on a scale of 1 to 10

Place a mark on the line above

When did this problem begin?

....

....

Is this problem (circle) **Occasional** **Frequent** **Constant** **Intermittent**

What makes this worse?
………
….

What makes this better?
………
….

Does it radiate or cause problems elsewhere?
………
………
……..

How is this impacting your quality of life presently?
………
………
……..

Is this becoming worse?
………
………
……..

Is the problem worse during a certain time of the day? If **Yes**, when?
………
………
……..

Have you seen other professionals for this?
………
…
………
…

Treatment and
results ………

Recent tests done
………

Do you think you will need to change some behaviours or habits to achieve the results in health you are after?
………
….
………
….

Any significant injuries, falls, vehicle accidents or traumas? If yes please explain
………
….
………
….

Any fractured bones or dislocations? ……………………………………………………………………………………………………

What is your average number of hours
sleeping? ……………………………………………………………………………………………………

Do you fall asleep well? ☐ Yes ☐ No

Do you wake during the night? ☐ Yes ☐ No If so how many
times? ……………………………………………………………

How would you rate your energy levels out of 10?

None 1 2 3 4 5 6 7 8 9 10 Great

How much water do you drink? ………………L/day

How much caffeine do you drink? E.g. Coffee, Tea, Soda

……
..

Are you exposed to pollutants, chemicals, aerosols, odours etc?

……
..

Are you taking any drugs, medications or supplements?

……
……
……..

Who else do you use as part of your health team?

……
……
……..

PARENTS / GUARDIANS: Please note any health issues that are past or present with family members such as parents, siblings, children.
Eg: Cancer, Heart Disease, Diabetes

……
……
……..
……
….

Do you regularly exercise or move?

……
……
……..

What are your favourite pastimes?

……
……
……..

Can you remember a time when you had excellent health?

……
…

What were you doing differently compared to now?

……
….

Have you experienced any of the following (Tick appropriate box):

Past Present

- ☐ ☐ Abdominal Pain
- ☐ ☐ Headaches
- ☐ ☐ Stroke
- ☐ ☐ Anxiety
- ☐ ☐ Insomnia
- ☐ ☐ Dizziness
- ☐ ☐ Sinus Trouble
- ☐ ☐ Ear Disorders
- ☐ ☐ Hay Fever
- ☐ ☐ Recurrent Sore Throats
- ☐ ☐ Asthma
- ☐ ☐ Chronic Cough
- ☐ ☐ Indigestion/Reflux
- ☐ ☐ Nausea/Vomiting
- ☐ ☐ Allergies
- ☐ ☐ Constipation
- ☐ ☐ Cancer
- ☐ ☐ Seizures
- ☐ ☐ Swelling Legs
- ☐ ☐ Swelling Arms

Past Present

- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ Urinary Disorders
- ☐ ☐ Bed Wetting
- ☐ ☐ Menstrual Disorders
- ☐ ☐ Sexual Disorder
- ☐ ☐ Chronic Fatigue Syndrome
- ☐ ☐ Sleeping Problems
- ☐ ☐ Jaw/TMJ Problems
- ☐ ☐ Soreness in Neck
- ☐ ☐ Shoulder Pain/Stiffness
- ☐ ☐ Arm Pain/Weakness
- ☐ ☐ Elbow Pain
- ☐ ☐ Pins & Needles of Hands
- ☐ ☐ Loss of Grip
- ☐ ☐ Wrist or Hand Pain
- ☐ ☐ Mid Back Pain/Stiffness
- ☐ ☐ Pain in Ribs
- ☐ ☐ Fertility Challenges
- ☐ ☐ Thyroid
- ☐ ☐ Prostate

Past Present

- ☐ ☐ Low Back Pain/Stiffness
- ☐ ☐ Hip Pain or Stiffness
- ☐ ☐ Buttock Pain
- ☐ ☐ Leg Pain
- ☐ ☐ Leg Cramps
- ☐ ☐ Vascular Problem
- ☐ ☐ Pins & Needles of Legs
- ☐ ☐ Knee Trouble
- ☐ ☐ Foot or Ankle Trouble
- ☐ ☐ Pins & Needles of Feet
- ☐ ☐ Osteoporosis
- ☐ ☐ Arthritis
- ☐ ☐ Diabetes
- ☐ ☐ High Blood Pressure
- ☐ ☐ Chronic Tension/Stress
- ☐ ☐ Loss of Taste
- ☐ ☐ Significant weight loss/gain in short time period
- ☐ ☐ Colds

Other: ....

How motivated are you to change your health?

Not at all 1 2 3 4 5 6 7 8 9 10 Very