CHIROPRACTIC • HEALTH COACHING

CHILD SPINAL AND POSTURAL EXAMINATION

Dear Parent,
It is our pleasure to welcome you to our clinic.
Please complete the following questionnaire. Your answers will help us determine whether chiropractic can help your child.

Thank you.

Childs Name: .... DOB: / / Age: ....

Parents Names: Father ....

Mother...

Address:...

....Postcode:.....................

Home Phone: ....Mobile: ....

Email: ....

Other Children's Names:

.... DOB: / / Age: ....

.... DOB: / / Age: ....

.... DOB: / / Age: ....

Who referred you to our clinic?

....

What concerns do you have regarding the health of your child?

....

....

....

....

BIRTH

The birth of your child can give vital clues as to potential spine problems. Please answer the following questions very carefully

Was your child delivered:

- ☐ Normally
- ☐ Premature
- ☐ Caesarean
- ☐ Forceps
- ☐ Suction/Vacuum
- ☐ Breech
- ☐ Posterior
- ☐ At term
- ☐ Late
- ☐ Chemically Induced
- ☐ Other ....

Birth weight... **Apgar Scores** .... **&** ....

How long were you in labour..................Hrs How long did you "push" for....................min/hr

Do you believe the birth was traumatic for your child? YES ☐ NO ☐

Was your child's head mis-shapen? YES ☐ NO ☐

Was there any delivery complications? YES ☐ NO ☐

Details...

....

....

How long until first breastfed?..

Any medications needed? ....

Any treatment provided since birth? ....

BIRTH TO SIX MONTHS:

Was your child breast fed? YES ☐ NO ☐ For how long? ....

Was your child formula fed? YES ☐ NO ☐ For how long? ....

Did your child suffer with colic? YES ☐ NO ☐ If yes, was it mild ☐ moderate ☐ severe ☐

Did your child suffer with reflux? YES ☐ NO ☐ If yes, was it mild ☐ moderate ☐ severe ☐

Would you say your child was a:

Very poor sleeper ☐ Poor sleeper ☐ Average sleeper ☐ Good sleeper ☐ Very good sleeper ☐

MEDICAL HISTORY

When did your child start on solids...months

How did they react?...

Are your child's bowel movements consistent? YES ☐ NO ☐

When did your child first roll? .... months

How long did your child crawl for?... months

Did they crawl properly? (e.g Bum shuffle) ....

When did you child sit up? ....months

Is your child accident prone? YES ☐ NO ☐

Has your child had any significant falls? YES ☐ NO ☐

Please describe any: ....

....

....

Has your child ever been involved in a motor vehicle accident? YES ☐ NO ☐

Is your child on medication? Describe: ....

Vaccination history? YES ☐ NO ☐

Has your child had any diseases/illnesses YES ☐ NO ☐

If yes, please describe...

....

Has your child been hospitalized or needed surgery? YES ☐ NO ☐

If yes, please describe ....

....

Has your child had any broken bones or sprain injuries? YES ☐ NO ☐

If yes, please describe: ....

....

Has your child had a learning disorder? YES ☐ NO ☐

Does your child have any allergies or sensitivities? YES ☐ NO ☐

How many times has your child taken antibiotics?

In the last six months...During lifetime......................................

How many other doses of other prescription medication has your child taken?

In the last six months...During lifetime......................................

Rate your child's energy levels:

1 2 3 4 5 6 7 8 9 10

PREVIOUS CHIROPRACTIC CARE

Has your child had previous chiropractic care? YES ☐ NO ☐

Reason for care? ....

Date of last care / / Name of chiropractor: ....

Location of clinic .... Were X-rays taken? YES ☐ NO ☐

How would you describe the care received? Excellent ☐ Good ☐ Fair ☐ Poor ☐

OTHER PROBLEMS

- ☐ Headache
- ☐ Neck pain
- ☐ Constipation/Diarrhoea
- ☐ Sinus pain
- ☐ Bedwetting
- ☐ Growing pains
- ☐ Loss of appetite
- ☐ Visual Disorders
- ☐ Arm/Leg Pain
- ☐ Learning Difficulties
- ☐ Digestive disorders
- ☐ Fever
- ☐ Joint pain
- ☐ Travel sickness
- ☐ Seizures
- ☐ Recurring Fevers
- ☐ Ear, nose, throat, and chest problems
- ☐ Musculoskeletal issues
- ☐ Allergies
- ☐ Back Pain
- ☐ Earaches/Infections
- ☐ Recurrent Tonsillitis
- ☐ Recurrent chest infections
- ☐ Hyperactivity
- ☐ Poor sleeping habits
- ☐ Constant fatigue
- ☐ Poor Co-ordination
- ☐ Recurrent stomach aches
- ☐ Scoliosis
- ☐ Convulsions
- ☐ Asthma
- ☐ Night Terrors
- ☐ Chronic colds
- ☐ Hip problems
- ☐ GI tract issues
- ☐ Neurological disorders