



Loving Life Chiropractic **Baby/Infant Questionnaire** **(0-4 years)**

"Helping You Do What You Love For Longer"



Welcome to Loving LIFE Chiropractic. We intend to give you and your child the very best service possible and in order to do so we need further information about your history and your expectations.

At Loving LIFE Chiropractic we do not diagnose or treat symptoms, disease or illness but we are concerned with restored function in the nervous system and balance in the spine. We achieve this by correcting interferences in the spine and nervous system called VERTEBRAL SUBLUXATIONS. All information is treated in the strictest confidence.

Date DD/MM/YY: / /20__

Parent/Guardian Details First name: _____ Last name: _____
Date of Birth DD/MM/YY _____ Age: _____ Address: _____

City: _____ Post Code: _____
Home Phone: _____ Work Phone: _____ Mobile Phone: _____
E mail: _____ Occupation: _____
Business Address _____ Spouse/Partner's name: _____
Marital status _____ No of Dependent Children: _____ Ages: _____ First Names: _____

How did you hear about our practice?

☐ Referred by someone (please specify) _____ ☐ newspaper ☐ GP/Health professional
☐ Google ☐ signage ☐ Other (please specify) _____

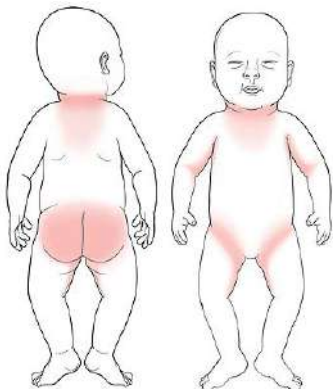
Baby/Infant Details First name: _____ Last name: _____
Date of Birth DD/MM/YY _____ Age: _____ Is address as above? **yes** ☐ no ☐ If no please provide details:
Address: _____

City: _____ Post Code: _____

What is your main reason for attending this office?

☐ A desire to improve baby's overall wellbeing ☐ A concern about a specific symptom/health challenge
What do you feel is your main symptom/health challenge? _____
How did this problem start? _____
Have there been similar problems in the past? _____
Has it recently ☐ got worse ☐ stayed the same ☐ started and stopped
Who else (Chiro/GP/Physio etc) have you seen for this specific health challenge? _____ When? _____
Results _____ If you have a GP what is their name/address? _____

Can we thank them for referring you to us?(circle) Y / N



On the diagram indicate any areas which seem to give baby distress. Please describe as best you can.

What is the biggest improvement you would like to see in your child?
e.g. feed better, more sleep, less stomach issues, put on weight.

Mark on the line how you would rate your child's **CURRENT HEALTH** in general.

⊕↓ 1 2 3 4 5 6 7 8 9 10 ↓⊙
Poor Health Excellent Health

Why do you feel that they are at this health level : _____

From 1 -10 how committed are you to improving this? _____

↓ 1 2 3 4 5 6 7 8 9 10 ↓⊙
No commitment Fully Committed

For Moms

Was your pregnancy full term yes ☐ no ☐ If no, how many weeks gestation? ____ wks How long was delivery? _____ hrs

Was the birth a usual birth (on back in hospital bed) ☐ or a natural birth (freedom to move in birthing centre/home, often on all fours/squatting and gravity assisted) ☐

Did your child's birth have any of the following:

- | | | | |
|---|---|---------------------------------------|---|
| ☐ Pulling in delivery | ☐ Premature | ☐ Drug induced | ☐ Prolonged delivery |
| ☐ Breech | ☐ Cord around neck | ☐ Forceps | ☐ Gas and air |
| ☐ Vacuum Extraction | ☐ C-Section | ☐ Epidural | ☐ Misshapen head |
| ☐ Unusual colour of baby | ☐ Obvious Injury to baby | ☐ Other _____ | |

Any other complications and when they occurred _____

Were you under chiropractic care before and during the birth? yes ☐ no ☐

Did you have your pelvis checked for alignment and subluxation correction after giving birth? yes ☐ no ☐

Did baby get checked for alignment and subluxation correction after the birth? yes ☐ no ☐

Tell us more:

Did you breastfeed yes ☐ no ☐ If yes for how long? _____ Formula after? yes ☐ no ☐

Did you take any of the following during the pregnancy (and frequency):

- ☐ Alcohol _____/day/week ☐ Prescription or recreational drugs _____/day/week ☐ Cigarettes _____/day/week ☐ Prolonged delivery

History of All Health Challenges/Symptoms

This is your opportunity to tell us about all your child's health challenges, past and present, **whether you believe they are connected to your current main concern or not.**

Tick all conditions applicable to your child and **for each tick please provide further details in the table** that follows:

- | | | | |
|---|--|---|--|
| Fall from changing table ☐ | Frequent crying spells ☐ | Frequent colds ☐ | Asthma ☐ |
| Convulsions ☐ | Numb/painful areas ☐ | Eye Problems ☐ | Chest issues ☐ |
| Dizziness ☐ | Short/long sighted ☐ | Chronic cough ☐ | Leg/Knee pain ☐ |
| In car accident ☐ | Play in "Jolly Jumper" ☐ | Vaccine reaction ☐ | Fall from bike ☐ |
| Deafness ☐ | Breathing problems ☐ | Diarrhoea/constipation ☐ | Scoliosis ☐ |
| Colic ☐ | Ear infections/ringing ☐ | Loss of sleep/insomnia ☐ | Loss of weight ☐ |
| Bed-wetting ☐ | Irregular heart beat ☐ | Anaemia ☐ | Sports accident ☐ |
| Low back pain ☐ | Liver/kidney/spleen/other organ issues ☐ | | Neck pain ☐ |
| Pain between shoulders ☐ | OTHER (please detail in table) ☐ _____ | | |

Please give further details of conditions ticked above (1 line per checked box/use separate sheet as necessary):

Health Challenge/Symptom	Date First Noticed	Any event linked to onset?	How does/did it affect Quality of Life?	Date ceased (if applicable)	Other Remarks

Practice Policy

In this office we practice the First Principle of Chiropractic and as such we aim to identify the cause of poorly expressed health due to interference in the nervous system at the level of the spine. These interferences are called "Vertebral Subluxations".

At Loving Life Chiropractic our aim is not to diagnose or treat your child's symptoms, disease or illness but we are concerned with the restoration of full function and healing. Once the body returns to a state of balance (homeostasis) it is able to deal much more readily with any health challenges and in turn people under our care often find that their symptoms abate as the CAUSE is corrected.

1. A recommended schedule of care will be outlined which is aimed at correcting vertebral subluxations and improving spinal health within a reasonable time period and we strongly recommend that this schedule is adhered to. If there is a need to reschedule appointments we will do so as close to the original appointment in order to maintain momentum in the healing processes. **If you fail to attend an appointment or reschedule without giving at least 12 hours notice then you give us permission to charge full rate for that appointment.**
2. Your normal visits will be conducted in our open room. If you wish to discuss something of a confidential nature outside of the regular Progress Exams please make an appointment at the front desk for a Private Visit.
3. Your documents and notes are treated in the strictest confidence and will not be discussed or released to any person (e.g. lawyer or insurance official) without your written consent.
4. Most people are very pleased with their care and tell their friends and families about us. However, if you believe any aspect of your care in our practice can be improved please tell us immediately. We are here to serve you and we are happy to receive feedback, both positive and negative.
5. Children are more than welcome in this Family Practice and whilst we aim to provide as safe an environment as possible **their safety and behaviour remains your responsibility.**

Please sign here to indicate you have read and understand the practice policy.

Signature: _____ Date: _____

Name(PRINT): _____ Relationship to Child: _____

Chiropractic Care Consent

Chiropractic has established a reputation for providing excellent results in the promotion of good health and well being through the improvement of nervous system and spinal function. Everyone is individual and unfortunately no guarantees can be offered.

Please note the following are based on adult cases. Children are adjusted VERY differently to adults with very little force being used.

Occasionally people under care experience mild healing effects and reactions such as muscle stiffness, local tenderness, tiredness, headaches, "flu-type" symptoms, release of emotions (such as crying) or dizziness. On very rare occasions 1 in 10,000 people report rib fracture. Whilst often reported anecdotally, serious injuries such as stroke are so extremely rare that they are reported as being less than 1 stroke per 2 Million cervical adjustments. To put this into perspective, hospitalisations from the mildest of medical intervention such as a use of anti-inflammatory medications (e.g. IbuprofenTM) are estimated at 40,000 per Million (i.e. 80,000 times more likely) and deaths at 4000 per Million (i.e. 8,000 times more likely) respectively.

There are no definite tests to indicate the risks to an individual, however extensive, prolonged, studies show that qualified, well-trained chiropractors provide an extremely safe form of care.

I give consent to my child receiving a chiropractic assessment which may includes a non-intrusive Scan and a full hands-on, examination at this practice. When deemed appropriate by the Chiropractic Doctor I consent to my child receiving a chiropractic adjustment.

Signature: _____ Date: _____

Name(PRINT): _____ Relationship to Child: _____