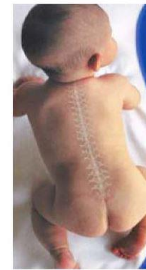
Loving Life Chiropractic
Baby/Infant Questionnaire
(0-4 years)

"A Better Way to Family Health"



Welcome to Loving LIFE Chiropractic. We intend to give you and your child the very best service possible and 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: _____ Aqes:_________ 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? ____

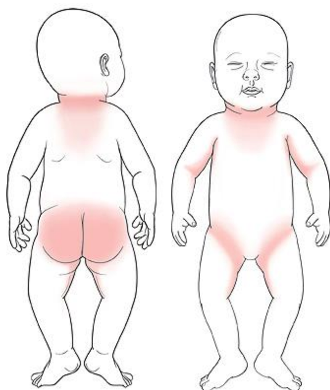
Have there been similar problems in the past? ____

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

Describe any complications and when they occurred ____

____

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 ______________________________		

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 on previous page (1 line per checked box). Use separate sheet as necessary:

Health Challenge/Symptom (continued from previous)	Date First Noticed	Any event linked to onset?	How does/did it affect Quality of Life?	Current frequency, constant, or date ceased?	Other Remarks

Surgery
Has your child had any surgery such as:
☐ Tonsils ☐ Appendix ☐ Spinal/Disc ☐ Endoscopy
☐ Heart surgery ☐ Trauma Repair ☐ Other ________________________

CHEMICAL STRESSES
Medication
Please detail any medication baby is taking (over the counter as well as prescribed / use separate sheet as necessary)
Name Dose What for?

____
____
____
____
____

Vitamins/Supplements
Indicate any vitamins or supplements your child takes____

Other Habits (please indicate quantities)

Does your child eat/drink:
☐ diet products ☐ dairy products ☐ meat products ☐ fish ☐ vegetarian/vegan only ☐ sugary foods

What type of activity do they most enjoy? ____
Do they sleep on their stomach? ☐ yes ☐ no
Was your child vaccinated? ☐ yes ☐ no
Did you know you had a choice of whether to get vaccinated or not? ☐ yes ☐ no
If vaccinated, were there any reactions / adverse changes in the first 6 months following the vaccine? ☐ yes ☐ no

If yes, please provide details ____

EMOTIONAL STRESS (e.g. unstable family situations, adoption, house move)
What degree of emotional stress has your child been under:

In the Past ☐ None ☐ Light ☐Moderate ☐ Heavy
At Present ☐ None ☐ Light ☐Moderate ☐ Heavy

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

PLEASE CAREFULLY READ AND SIGN THE FOLLOWING POLICY AND CONSENT DOCUMENT

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 can 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.

Ethically, before starting your care we need you to be informed of any risks so please read the following carefully. **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. Ibuprofen™) 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: ________________________