



1 - 4 years

Child Health History

Child Name: _____ D.O.B: ____/____/____ Gender: M ☐ F ☐

Parent/Guardian Name(s): _____

Siblings (names and age): _____

Address: _____

Phone: _____ Email: _____

Paediatrician/Dr: _____

Do you have private health cover: Yes / No. If so, which fund? _____

How did you hear about Tamar Chiropractic? _____

Reason for today's visit (*if coming in for a check-up, please leave the following 6 questions blank*):

When did this condition begin? _____

Have there been any change(s) in condition since onset? _____

What makes the condition better? _____

What makes the condition worse? _____

Have there been previous episodes? _____

If other health practitioners have been consulted, please provide details: _____

Is your child currently taking any medication? Yes / No. Please list: _____

Please list any previous medications: _____

Please list medical illnesses/diagnoses: _____

Has your child ever been hospitalised? _____ Has your child ever had surgery? _____

Please circle whether your child has suffered from any of the following symptoms, whether past or present:

Headache	Sinus troubles	Scoliosis	Colic
Ear ache/infections	Tonsillitis	Reflux	Constipation/Diarrhoea
Hip problems	Asthma/chronic cough	Frequent colds & flu's	Digestive disorders
Developmental delay	Preferred head position	Back arching	Poor sleeping habits
Migraine	Poor coordination	Motion sickness	Allergies

Other: _____

So we can help form an idea of how we can best help your child, it is important that we get a complete picture of your child's health history.

Yes ☐ No ☐ Was your child delivered by caesarean?

Yes ☐ No ☐ Were forceps or vacuum extraction used during birth?

Yes ☐ No ☐ Was there tugging on your babies neck during the birth process?

Yes ☐ No ☐ Is (or was) your child breast fed? If yes, how long was he/she breastfed? _____

Yes ☐ No ☐ Is (or was) your child formula fed? Which formula? _____

Yes ☐ No ☐ Has your child had any falls or trauma?

Yes ☐ No ☐ Has your child ever been in a car accident?

Yes ☐ No ☐ Has your child ever had any antibiotics?

Yes ☐ No ☐ Does your child release their bowels every day?

Yes ☐ No ☐ Is your child taking any over the counter or prescription medication? _____

Yes ☐ No ☐ Is your child taking any vitamins/supplements? _____

Tick any of the following that your child has had or does have:

☐ ADD / ADHD / ASD	☐ Anxiety	☐ Depression	☐ Learning Difficulties
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Other (please explain) _____

What does your child normally eat for Breakfast? _____

What does your child normally eat for Lunch? _____

What does your child normally eat for Dinner? _____

What does your child normally eat for Snacks? _____

CANCELLATION POLICY

Tamar Chiropractic & Allied Health is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us by 5pm the business day prior to your scheduled appointment to notify us of any changes. Failure to do so incurs a fee equal to that of the booked appointment.

Print Parent Name: _____

Signature: _____

Date: _____