5 -12 years

Primary Age 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:

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

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* ☐ 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

Other (please explain) _____

Please grade the present levels of stress using - High, Medium or Low:

At school: *At home:* *At play:*

_____

Using Good, Average or Poor please describe your child's:

Eating habits: *Exercise habits:* *Sleep:* *General health:* *Mindset:*

_____

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:_____