Child Health History

Childs Full name:	**Date:**
Parents names:	
Address: Street Suburb State P/Code	
Home phone:	**Work phone:**
Mobile:	**Email address:**
Date of birth:	**Age:**

Whom may we thank for referring you? _____

What brings you and your child in to see us today?

☐ **My child is here for a general health evaluation.** ☐ **My child is suffering from a particular health problem/symptom.**

Please describe your child's complaint/s, including when and how they started:

_____

_____

_____

_____

What treatment and tests has your child received for his/her problems so far?

_____

_____

Has your child ever seen a chiropractor? __ Y __ N Who? _____

Who is your child's pediatrician? Name: _____ **Location:** _____

Was your child delivered…… vaginally or…….. by caesarian ?

Yes/ No Were forceps or vacuum extraction used? _____

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 Has your child had any other illnesses? _____

Yes/ No Has your child taken any medication in the past? _____

Yes/ No Has your child been vaccinated? _____

Yes/ No Has your child had any surgeries or hospital visits? _____

Yes/ No Does your child release their bowels every day? _____

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? _____

_____

Is your child taking any over the counter or prescription medication? _____

Is your child taking any vitamins/supplements? _____

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

☐ **Allergy/sinus**	☐ **Arthritis**	☐ **Asthma**	☐ **Colic**	☐ **Learning Difficulties**	☐ **Depression**
☐ **Diabetes**	☐ **Eczema**	☐ **Ear Infections**	☐ **Reflux**	☐ **Back / Neck Pain**	☐**Torticollis**
☐ **Constipation**	☐ **Nervousness**	☐ **Headaches/ Migraines**	☐ **ADD/ ADHD**	☐ **Bedwetting**	☐ **Frequent Colds/Flu**

Other (please explain) _____

I, the undersigned, being the parent/guardian of _____, certify that the above information is correct. I authorise The Innate Connection Chiropractic to perform an examination and, if necessary following appropriate discussion of examination findings, administer chiropractic treatment for this child. I authorise The Innate Connection Chiropractic to contact and release information to other health care providers the child has to coordinate care, and to release health information for insurance reimbursement purposes.

_____

Print name of parent or legal guardian

_____ _____/_____/_____

Signature of Parent/Guardian **Date**

Primary Age Child Health History

Childs Full name:			
Parents names:			
Address: Street	Suburb	State	P/Code
Home phone:	**Work phone:**		
Mobile:	**Email address:**		
Date of birth:	**Age:**		

Whom may we thank for referring you? _____

Why did you bring your child in to see us today?

☐ **My child is here for a general health evaluation.** ☐ **My child is suffering from a particular health problem/symptom.**

Please describe your child's complaint/s, including when and how they started:

_____

_____

_____

_____

_____

_____

What treatment and tests has your child received for his/her problems so far?

_____

_____

Has your child ever seen a chiropractor? __ Y __ N If so, whom? _____

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

☐ **Allergy/sinus**	☐ **Anxiety**	☐ **Asthma**	☐ **Colic**	☐ **Learning Difficulties**	☐ **Depression**
☐ **Diabetes**	☐ **Eczema**	☐ **Ear Infections**	☐ **Reflux**	☐ **Back / Neck Pain**	☐**Torticollis**
☐ **Constipation**	☐ **Nervousness**	☐ **Headaches/ Migraines**	☐ **ADD/ ADHD**	☐ **Bedwetting**	☐ **Frequent Colds/Flu**

Other (please explain) _____

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.

Was your child delivered by caesarian? _____

Were forceps or vacuum extraction used during birth? _____

Was there tugging on your babies neck during the birth process? _____

Has your child been vaccinated? _____

Has your child had any falls or trauma? _____

Has your child ever been in a car accident? _____

Has your child ever had any antibiotics? _____

Has your child had any other illnesses? _____

Has your child taken any medication in the past? _____

Has your child had any surgeries or hospital visits? _____

Does your child release their bowels every day? _____

Is your child taking any over the counter or prescription medication? _____

Is your child taking any vitamins/supplements? _____

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:	Mind set:

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_____

Print name of parent or legal guardian

_____ _____/_____/_____

Signature of Parent/Guardian **Date**