Move It CHIROPRACTIC
Our family caring for your family.

Confidential Paediatric Patient Information & History Form (0-5yrs)

Welcome to Move It Chiropractic. Please complete this form to the best of your ability & add any additional notes/information you feel would be beneficial for the Doctor to know to assist you most effectively.

PATIENT INFORMATION

Today's Date: ____ / ____ / ____ First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ Age: _____

Mother's Name: _____ Father's Name: _____

Parent/Guardian Mobile #: _____ Parent/Guardian Home #: _____

Parent/Guardian Email: _____

Emergency Contact: _____ Contact Number: _____ Relationship: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

We appreciate referrals, who may we thank for referring you? ☐ Person (please specify) _____

☐ Online Search ☐ Website ☐ Facebook ☐ Signage ☐ Medical Practitioner ☐ Other _____

Private Health Fund: _____ Member Number: _____

Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐ Medicare Ref Number (number beside your name): ☐

Has your child had chiropractic care before ☐ No ☐ Yes (by whom) _____ (in what year) _____

Has your child previously had any X-Rays taken? ☐ No ☐ Yes (year taken) _____ (area of the body) _____

HOW CAN WE HELP YOUR CHILD?

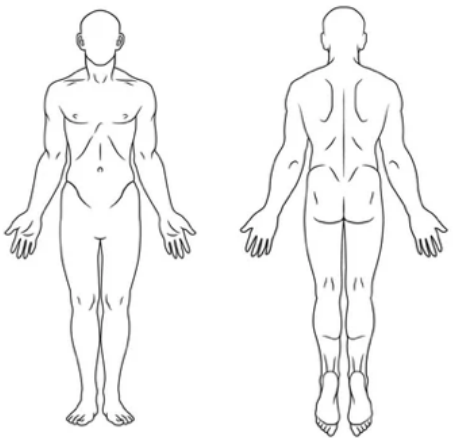
What brings you to us today? _____

_____

If your child is already experiencing any symptoms, what are they? _____

_____

Please circle any areas where they have pain or other symptoms



Any other problems you are concerned with:

_____

_____

_____

HEALTH & ILLNESS HISTORY

Sporting & exercise programs: _____

Hobbies: _____

Accidents & injuries: _____

Operations: _____

Medications/supplements: _____

PTO

PREGNANCY, BIRTH & INFANCY

Did the child's mother have any issues during pregnancy?

☐ Back Pain ☐ Morning sickness ☐ Gestational diabetes ☐ Preeclampsia ☐ High blood pressure
☐ Anaemia ☐ Placenta previa ☐ Abdominal pain ☐ Constipation ☐ Other _____

Did the child's mother take any supplements during pregnancy or are they currently?

please specify:_____

Was your child's birth: ☐ Hospital ☐ Home ☐ Birthing Centre ☐ Other _____

Was the birth vaginal: ☐ No ☐ Yes

Was labour: ☐ Spontaneous ☐ Induced

Was the birth assisted: ☐ No ☐ Yes, please specify:

☐ Forceps ☐ Planned C-Section ☐ Emergency C-Section ☐ Vacuum ☐ Other _____

Was there any:

☐ Foetal Distress ☐ Breach Presentation ☐ Foetal Presentation ☐ Meconium Staining ☐ Complications

please specify:_____

Were medications or epidurals given to the mother during birth? ☐ No ☐ Yes, please specify:

Did the child's mother have any difficulties with breastfeeding? ☐ No ☐ Yes

Did the child's mother & the child have any difficulty bonding? ☐ No ☐ Yes

GROWTH & DEVELOPMENT

Do you have any concerns about your child's:

☐ Hearing ☐ Vision ☐ Balance ☐ Co-ordination ☐ Head Shape ☐ Other, please specify:

Do your child's sleeping patterns seem normal? ☐ Yes ☐ No Hours per day: _____

How would you rate your child's quality of sleep? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What position does your child sleep in? ☐ Back ☐ Side ☐ Stomach

How often are your child's bowl movements? _____

Are your child's stools: ☐ Soft ☐ Runny ☐ Hard ☐ Smelly

How would you rate your child's posture? Poor

0	1	2	3	4	5	6	7	8	9	10

Excellent

Does your child have any behavioural issues? ☐ No ☐ Yes, please specify:

Does your child have difficulty with co-ordination? ☐ No ☐ Yes, please specify:

What is the average time spent at a computer/iPad/iPhone/game console/watching television etc each week? _____ Hours