Move It CHIROPRACTIC
Our family caring for your family

Confidential Paediatric Patient Information & History Form (5-16yrs)

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? ____

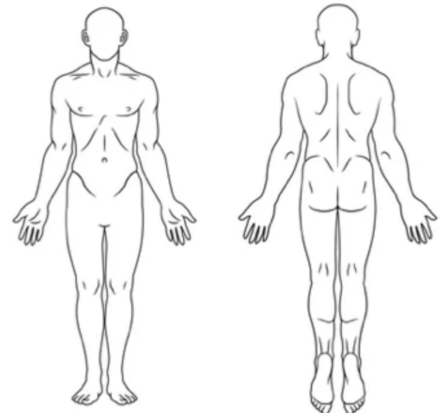
____

How intense are their symptoms? No Symptoms

0	1	2	3	4	5	6	7	8	9	10

Intense Symptoms

Please circle any areas where they have pain or other symptoms



Any other problems you are concerned with:

____

____

IMPACT OF THEIR SYMPTOMS

How is this symptom/condition interfering with their life? (please check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Exercise	☐	☐	☐	☐
Patience	☐	☐	☐	☐
Creativity	☐	☐	☐	☐
Other ____________	☐	☐	☐	☐

PTO

How committed are you to correcting this issue?

Not Committed	0	1	2	3	4	5	6	7	8	9	10	Very Committed

What are your health goals?

IMMEDIATE: ______

SHORT TERM: ______

LONG TERM: ______

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 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 behaviour 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

Does your child:

☐ Have difficulty learning to skip? ☐ Avoid activities with movement or balance?
☐ Frequently drop things? ☐ Frequently walk into furniture &/or doorways?
☐ Sleep with lights on? ☐ Write with their tongue hanging out?

Does your child have difficulty with the following?

☐ Reading ☐ Spelling ☐ Handwriting ☐ Math ☐ Completing homework
☐ Sport ☐ Following Directions ☐ Organisation ☐ Concentration ☐ Remembering Information

HEALTH & ILLNESS HISTORY

Sporting & exercise programs: ______

Hobbies: ______

Accidents & injuries: ______

Operations: ______

Medications/supplements: ______

(please check where appropriate)

☐ Abdominal pain or digestive problems
☐ Allergies, asthma, or hay fever
☐ Anxiety, depression, stress, or psychological problems
☐ Lung or breathing problems
☐ Epilepsy or neurological problems
☐ Headaches, migraines, or dizziness
☐ Bedwetting or bladder problems
☐ Low energy, fatigue, or trouble with sleep
☐ Sinus, vision, or hearing problems
☐ Other ______