CHILD'S FIRST CHIROPRACTIC VISIT

Date:_____
Name:_____**Birthdate:** _____
Address:_____**P/C**_____
Home Phone:_____**Mobile:**_____
Parent/Guardians name:_____
How did you hear about our office:_____

Personal details:

What concerns do you have regarding your child's health?_____
_____
_____

Your pregnancy: Did you have (please tick):
Difficulties conceiving?_____ Miscarriages?_____
Smoke or drink?_____ Emotional upsets?_____
Exercise? _____ Healthy diet?_____
Falls? _____ Take any medication?_____
Accidents?_____ Morning sickness? _____

Birth details can give vital clues as to potential spinal problems.
Was your child delivered normally? Yes/No. Please circle:

Posterior	Breach	Induced
Forceps	Suction/vacuum	Caesarean
Premature	Term	Late

Were any drugs used in the birth?_____
Was the birth difficult or long? _____ Short _____
Do you believe the birth was traumatic for your child? yes/no
Apgar scores _____ _____
Was your child's head misshapen at birth? yes/no Bruised? yes/no
Were there any complications? Yes/no _____

BIRTH TO SIX MONTHS: Is/was your baby:
Breast Fed? yes/no For how long?_____
Right & left breast evenly? yes/no
Formula fed? yes/no From what age?_____ For how long?_____
Was/is your baby 'colicky'? yes/no Mild___moderate___severe___
Did/does your baby have reflux? yes/no 'Silent' reflux? yes/no
How does your baby sleep? Poor____ Fair____ Good____ Excellent____
Did/does your baby move his/her bowels daily? yes/no Easily? yes/no
Was/is your baby very irritable or unsettled? yes/no

Are you concerned about the shape of your baby's head? _____
Vaccination reactions: _____

OTHER PROBLEMS: Is or has your child ever experienced (Please circle):

Constipation	Diarrhoea	Hyperactivity	Attention difficulties	Social problems
Concentration problems	Learning difficulties	Behavioral problems	Seem uncoordinated	Recurrent colds/flu
Ear aches	Ear infections	Asthma	Allergies	Poor appetite
Lower back pain	Mid-back pain	Neck pain	Growing pains	Joint problems
Headaches	Sinus	Convulsions	Bedwetting	Scoliosis
Recurrent chest infxn	Recurrent tonsillitis	Chronic fatigue		

When did your child roll?_____ Sit_____
Did your child crawl? Yes/no What age?_____
When did your child walk?_____
Has your child been to hospital for any reason?_____
Has your child had any significant falls/accidents?_____
_____
Has your child broken any bones?_____
How many courses of antibiotics has your child had?
In the last 6 months_____ During their lifetime _____
Has your child had other prescription medication?
In the last 6 months_____ During their lifetime_____
How would you describe your child's eating habits:
Excellent_____Good_____Fair_____Poor_____Terrible_____

Is there anything else you would like the Chiropractor know about your child or his/her family? _____
_____
_____
_____