Frankston Chiropractic Centre
16 Cranbourne Road Frankston
VIC Australia 3199
T 03 **9783 4683 F 03 9783 4678**

Name of child:.. D.O.B:.. Age:.......................

Parent's names: Father:...

Mother:...

Address:..

.... P/C:.....................

Contact Phone Number:

Home:... Mobile:.. Work:..

Emails Address:..

Other children's names:

.... D.O.B:... Age:............

.... D.O.B:... Age:............

.... D.O.B:... Age:............

.... D.O.B:... Age:............

Who referred you to our clinic?...

Do you have private health insurance for chiropractic?...

What concerns do you have regarding the health of your child?

....

....

....

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BIRTH

The birth of your child can give vital clues to potential spinal problems. Please answer the following questions carefully.

Was your child delivered:

Normally	Yes/No	Breech	Yes/No
Posterior	Yes/No	Premature	Yes/No
At Term	Yes/No	Caesarian	Yes/No
Late	Yes/No	Forceps	Yes/No
Chemically induced	Yes/No	Suction/Vacuum	Yes/No

Other...

....

Birth weight:.................................... Apgar scores:................................

How long were you in labour?______hours How long did you "push" for?______mins/hours

Do you believe the birth was traumatic for your child? Yes/No

Was your child's head misshapen at birth? Yes/No

Were there any delivery complications? Yes/No

Details:...

....

....

....

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BIRTH TO SIX MONTHS

Was your child breast fed?	Yes/No	For how long?...
Was your child formula fed?	Yes/No	For how long?.........................Type....................

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Did your child suffer with colic? Yes/No — If yes: Mild/Moderate/Severe

Did your child suffer with reflux? Yes/No — If yes: Mild/Moderate/Severe

Would you say your child was a:

Very poor sleeper | Poor sleeper | Average sleeper | Good sleeper | Very good sleeper

OTHER PROBLEMS

Please indicate by circling any of the following conditions which your child has experienced in the past:

Headache	Allergies
Neck Pain	Back pain
Constipation/diarrhoea	Earaches/Infections
Sinus pain	Recurrent Tonsillitis
Bedwetting	Recurrent chest infections
Growing pains	Hyperactivity
Loss of appetite	Poor sleeping habits
Visual disorders	Constant fatigue
Arm/leg pain	Poor co-ordination
Learning difficulties	Recurrent stomach aches
Digestive disorders	Scoliosis
Fever	Convulsions
Joint pains	Asthma
Travel sickness	Night terrors
Seizures	Chronic colds
Recurring fevers	Hip problems

Other...

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MEDICAL HISTORY

How long did your child crawl for:..............months

Is your child accident prone? Yes/No Has your child had significant falls? Yes/No

Please describe any falls or accidents your child has had:..

....

Has your child ever been in a car accident? Yes/No

Is your child on medication? Yes/No Details...

.

Vaccination

History:...

Has your child ever been hospitalised or had surgery? Yes/No If yes please describe:

....

Has your child ever had any broken bones or sprains? Yes/No If yes please describe:

....

Has your child ever been assessed for the presence of scoliosis? Yes/No

Has your child ever had a learning disorder? Yes/No

How many times has your child taken antibiotics? In last 6 mths......... During lifetime.................

PREVIOUS CHIROPRACTIC CARE

Has your child had previous chiropractic care? Yes/No Reason..

Date of last care..................................... Name of Chiropractor...

Were X-rays taken? Yes/No

How would you describe the level of care received? Excellent Good Fair Poor

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