Child Chiropractic Examination (0 to 10 years)

Name of Child: _____ Age: _____ D.O.B: _____
Parents names: Mother _____
Father _____
Address: _____ Contact numbers: _____
_____ _____
Email: _____

Who may we thank for referring you to us?
_____

Please tick if you would like to receive updates via Email on our wellness seminars and other exciting events ☐

What concern do you have regarding the health of your child? Why have you brought them here?
_____
_____

Has your child been checked by another health care professional (e.g. Mid-wife, Pediatrician, GP, etc.) prior to today's consultation? If yes, when?
_____
_____

Past Chiropractic Care? Yes / No If YES, who? _____
The date of last visit? _____
Reason/s for the last visit? _____

Pregnancy History

Age of Mother _____ Previous Pregnancies Yes / No
No. of Pregnancies _____ No. of Births _____
No. of Children/siblings _____
Smoking/Alcohol use? _____ Trauma/Falls/Accidents? _____
Medication/recreational drug use during pregnancy (Please provide names)
_____
X-ray or Ultra-sound exposure? (Yes/No) _____
Health of mother during pregnancy (e.g. Hypertension, infections, pre-eclampsia, etc.)
_____
_____

Birth History

The birth of your child can give vital clues to potential spinal problems. Please provide the following information.

Length of gestation (from conception to birth)? _____
Length of labour? _____
Length of previous labours (if applicable)_____
Place of Birth? _____ Who assisted the birth? _____

Was your child delivered...

Chemically induced	Yes	No	Caesarian	Yes	No
Suction/vacuum	Yes	No	Forceps	Yes	No
Maternal Anesthesia	Yes	No			

Why was this method/s utilized? Were there other complications?

_____

_____

Do you think it was a Traumatic Birth? Yes No
Was the baby in Fetal distress? Yes No
Birthing presentation (Please circle)?

Occiput Posterior Occiput Anterior Breech

Apgar Score? After 1 minute _____
After 5 minutes _____

Neonatal History (Birth to first 28 days)

Length of sleep per day? _____
Length of sleep between feeds? _____
Preferred sleeping position (front, back or side)? _____
Breast fed or formula? _____ If Formula fed, at what age? _____
Frequency of feeding per 24 hours? _____
Length of each feed? _____ Amount fed each time? _____

Nursing difficulties (please circle)?

Regurgitation	Fussiness	Side-preference	Weak sucking
Gagging	Choking	Dribbling	Prolonged feed

Persistent crying? Yes No How long does your child cry? _____
Colic/reflux? Yes No Was your child's head mis-shapen at birth? Yes No
Persistent fever? Yes No

At what age did your child?
Respond to sound _____ Hold up head _____ Sit alone _____ Crawl _____

Follow an object _____ Vocalize _____ Teethe _____ Walk _____

Family History

Please note any health problems (i.e.: cancer, hereditary conditions, diabetes, heart disease) present in: Mothers family _____
Fathers family _____

Medical History

Is your child using medications? Yes No
Details

_____

_____

Number of times Antibiotics have been used?
In last 6 months? _____ Since birth? _____ Any reactions? Y / N

Vaccination Schedule:

What Vaccine?	What age?

Did your child have any reaction after vaccinations? Yes No
Hospitalisation or Surgical intervention? Yes No
Details _____
_____

Trauma/falls Yes No
Details _____
_____

Review of Systems

Does your child have any of the following? (Please tick)

General
- ○ Trouble sleeping
- ○ Weight loss or gain
- ○ Fatigue
- ○ Low energy

Head and Neck
- ○ Headaches
- ○ Dizziness
- ○ Irritability
- ○ Fatigue
- ○ Depression
- ○ Loss of balance
- ○ Loss of concentration
- ○ Fainting
- ○ Ears buzzing
- ○ Poor coordination
- ○ Vision changes
- ○ Loss of memory
- ○ Loss of smell
- ○ Loss of taste
- ○ Light sensitivity
- ○ Face flushed
- ○ Absent facial expressions
- ○ Droopy eyelids/face
- ○ Visual disorders
- ○ Learning difficulties
- ○ Hyperactivity
- ○ Allergies
- ○ Dental problems
- ○ Ear aches infections

Respiratory
- ○ Rattles
- ○ Wheezes
- ○ Vibrations
- ○ Difficulty breathing
- ○ Shortness of Breath
- ○ Sinus pain
- ○ Sinus congestion
- ○ Asthma
- ○ Recurrent Chest infections
- ○ Recurrent tonsillitis
- ○ Fainting
- ○ Sore throat
- ○ Bronchitis
- ○ Pneumonia

Cardiovascular
- ○ Blue tongue/lips
- ○ Cold hands/feet
- ○ Colour change in arms/legs
- ○ Chest pressure
- ○ Breast/Chest pain
- ○ Heart palpitations
- ○ Heart Murmurs

Gastrointestinal
- ○ Straining
- ○ Diarrhea
- ○ Constipation
- ○ Hard stools
- ○ Bleeding
- ○ Mucous
- ○ Bloating
- ○ Decreased Bowel movements
- ○ Loss of appetite
- ○ Digestive disorders
- ○ Stomach aches

Urinary
- ○ Bedwetting
- ○ Nappy rashes
- ○ Urinary tract infections
- ○ Other urinary problems

Musculoskeletal
- ○ Neck pain
- ○ Upper back pain
- ○ Low back pain
- ○ Radiating pain
- ○ Numbness in leg(s)
- ○ Hip problems
- ○ Knee problems
- ○ Shoulder problems
- ○ Ankle problems
- ○ Scoliosis
- ○ Growing pains

Do you have any other concerns?
_____
_____

Authorising Consent for Examination of a Minor (under 16 years):
Please Read Carefully

In order for the health professional as indicated below to make a determination on the suitability of my child's/guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child's interests.

Guardian/Parent's name _____

Signature _____ Date _____

Chiropractor's Signature _____ Date _____

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