

NEW CLIENT - CHILD



WELCOME TO FAMILY WELLNESS CHIROPRACTIC AND THANKYOU FOR CHOOSING US

Please fill in the following details for our records

CHILD'S NAME

DATE OF BIRTH

AGE

SEX

MALE / FEMALE

POSTAL ADDRESS

PARENT'S/GUARDIAN'S NAMES

PARENT'S/GUARDIAN'S CONTACT TELEPHONE NUMBERS

(HOME)

(WORK)

(MOBILE)

PARENT'S/GUARDIAN'S CONTACT EMAIL ADDRESS *

IS YOUR CHILD'S CHIROPRACTIC HEALTH CARE COVERED BY PRIVATE HEALTH INSURANCE?

YES

NO

NAME OF PRIVATE HEALTH INSURANCE FUND

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

SIGNAGE

ANOTHER HEALTH PROFESSIONAL

YELLOW PAGES

LOCAL DIRECTORY

FAMILY MEMBER

ACQUAINTANCE

ADVERTISING/ PROMOTION

PLEASE LIST...

IF WE WERE RECOMMENDED, PLEASE STATE WHO RECOMMENDED US:

MAY WE USE YOUR CHILD'S FIRST NAME ONLY TO THANK THE PERSON IN WRITING?

NAME OF PERSON:

YES

NO

THE BIRTH OF YOUR CHILD CAN GIVE VITAL CLUES TO POTENTIAL HEALTH PROBLEMS. WAS YOUR CHILD DELIVERED?

NORMALLY

BREECH

PREMATURE

CAESARIAN

FORCEPS

LATE

SUCTION

INDUCED

IS/WAS YOUR CHILD'S HEAD MIS-SHAPEN AT BIRTH?

YES

NO

WERE THERE ANY DELIVERY COMPLICATIONS?

YES

NO

IS/WAS YOUR CHILD BREAST FED?

YES

NO

FOR HOW LONG?

IS/WAS YOUR CHILD FORMULA FED?

YES

NO

FOR HOW LONG?

HAS YOUR CHILD RECEIVED CHIROPRACTIC CARE BEFORE?

YES

NO

IF YES, WHEN WAS HIS/HER LAST VISIT?

WERE X-RAYS TAKEN?

YES

NO

DO YOU HAVE ANY CONCERNS REGARDING THE HEALTH OF YOUR CHILD?

ABOUT YOUR HEALTH HISTORY

Answering the following questions will help us to review important aspects of your child's health history and lifestyle. This will enable us to best determine how we may help your child to achieve better levels of health and well being.

DOES YOUR CHILD HAVE OR HAS YOUR CHILD EVER HAD, PROBLEMS WITH ANY OF THE FOLLOWING? PLEASE TICK IF THE ANSWER IS YES.

- | | | |
|--|--|--|
| <input type="radio"/> ALLERGIES | <input type="radio"/> CIRCULATION | <input type="radio"/> LOW IMMUNE SYSTEM |
| <input type="radio"/> ABDOMEN | <input type="radio"/> DIARRHOEA/CONSTIPATION | <input type="radio"/> LUNGS |
| <input type="radio"/> ANXIETY/DEPRESSION | <input type="radio"/> DIZZINESS/BLACKOUTS | <input type="radio"/> NIGHT TERRORS/NIGHTMARES |
| <input type="radio"/> ARMS OR LEGS | <input type="radio"/> EARS/HEARING | <input type="radio"/> PANCREAS/SUGAR LEVELS |
| <input type="radio"/> ARTHRITIS | <input type="radio"/> EATING DISORDERS | <input type="radio"/> PSYCHIATRIC PROBLEMS |
| <input type="radio"/> ASTHMA | <input type="radio"/> EPILEPSY/CONVULSIONS | <input type="radio"/> REFLUX |
| <input type="radio"/> BALANCE | <input type="radio"/> FEVERS/SWEATS/CHILLS | <input type="radio"/> SENSATION CHANGES |
| <input type="radio"/> BED WETTING | <input type="radio"/> GROWING PAINS | <input type="radio"/> SPORTS INJURIES |
| <input type="radio"/> BLOOD DISORDERS | <input type="radio"/> HAY FEVER/SINUSES | <input type="radio"/> TONSILLITIS |
| <input type="radio"/> BLOOD PRESSURE | <input type="radio"/> HEADACHES/MIGRAINES | <input type="radio"/> TREMORS |
| <input type="radio"/> BOWEL/INTESTINES | <input type="radio"/> HEART DISEASE | <input type="radio"/> ULCERS |
| <input type="radio"/> BRUISING EASILY | <input type="radio"/> HYPERACTIVITY | <input type="radio"/> URINARY PROBLEMS |
| <input type="radio"/> CHEST PAINS | <input type="radio"/> LACK OF ENERGY | <input type="radio"/> VISUAL PROBLEMS |
| <input type="radio"/> COUGHING | <input type="radio"/> LEARNING DIFFICULTIES | <input type="radio"/> OTHER |

FOR HOW LONG DID YOUR CHILD CRAWL?

HAS YOUR CHILD EVER BEEN INVOLVED IN A CAR ACCIDENT OR A SIGNIFICANT ACCIDENT OF ANY KIND? YES NO

IS YOUR CHILD ON MEDICATION? YES NO

VACCINATION HISTORY

IS THERE ANY OTHER INFORMATION ABOUT YOUR CHILD'S HEALTH HISTORY (NOT LISTED ABOVE) THAT WE SHOULD KNOW ABOUT? IF YES PLEASE SPECIFY:

DOES YOUR CHILD HAVE A FAMILY HISTORY OF THE FOLLOWING? PLEASE TICK IF YES.

- | | | |
|--------------------------------------|---|---|
| <input type="radio"/> ASTHMA | <input type="radio"/> HEART DISEASE | <input type="radio"/> SKIN DISORDERS |
| <input type="radio"/> BLOOD PRESSURE | <input type="radio"/> KIDNEY DISEASE | <input type="radio"/> THYROID GLAND |
| <input type="radio"/> DIABETES | <input type="radio"/> MUSCULOSKELETAL DISEASE | <input type="radio"/> TUBERCULOSIS |
| <input type="radio"/> CANCER | <input type="radio"/> SCOLIOSIS | <input type="radio"/> OTHER – PLEASE LIST |

PLEASE PROVIDE FURTHER INFORMATION

YOUR HEALTH OBJECTIVES

People consult this Office with one or more of the following health objectives.
Please tick those which apply to you and/or your child.

- | |
|---|
| <input type="radio"/> CORRECTION OF THE UNDERLYING CAUSES OF MY SYMPTOMS AND HEALTH PROBLEMS |
| <input type="radio"/> PREVENTION OF THE DEVELOPMENT OF SYMPTOMS, HEALTH PROBLEMS AND DEGENERATION |
| <input type="radio"/> ACHIEVEMENT OF AN OPTIMAL LEVEL OF HEALTH AND WELL BEING FOR MY CHILD |
| <input type="radio"/> OPTIMAL HEALTH FOR MY WHOLE FAMILY |