Confidential Patient Case History

Welcome to Wheaton Chiropractic. Your answers to this health questionnaire will help us to determine if chiropractic can help your child and enable us to devise the most effective treatment plan if yours is a chiropractic case. Thank you.

CHILD'S NAME : _____ DATE :_____
PARENT/GUARDIAN:_____
ADDRESS : _____ POST CODE :_____
PHONE : (Home) _____(Work) _____(Mobile) :_____
E-mail : _____ D.O.B :_____ Age : _____

I have been referred to this office by Mr /Mrs /Dr : _____
Family ☐ Friend ☐ Sign ☐ Telephone Directory ☐ Other ☐
Has your child had previous Chiropractic Care? Yes / No.
Name of Chiropractor : _____ Date of last chiropractic care : _____
Reason for care: _____ Were x-rays taken? Yes / No
What concerns do you have regarding the health of your child? _____
_____
_____
_____
_____

Birth

The birth of your child can give vital clues as to potential spinal problems. Please answer the following questions very 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 for? _____ 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 mis-shapen at birth? Yes / No
Were there any delivery complications? Yes / No
Details: _____
_____
_____
_____

Birth to Six Months

Was / Is your child breast fed?	Yes / No	For how long? _____
Was / Is your child formula fed?	Yes / No	For how long? _____ Type _____
Did your child suffer from colic?	Yes / No	If yes, how bad was it? Mild Moderate Severe
Did your child suffer from reflux?	Yes / No	If yes, how bad was it? Mils 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	Neck Pain	Back Pain	Allergies
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_____

Medical History

How long did your child crawl for? _____ months
Is your child accident prone? Yes / No Has your child had any significant falls? Yes / No
Please describe any falls or accidents your child has had.

_____
_____

Has your child ever been involved in a motor vehicle accident? Yes / No
Is your child on any medication? Yes / No
Vaccination History? _____
Has your child had any diseases / illnesses? Yes / No
Has your child ever been hospitalized or had surgery? Yes / No If yes, please detail:

_____
_____

Has your child ever had any broken bones or sprain injuries? Yes / No If yes, please detail:

_____
_____

Has your child ever been assessed for the presence of scoliosis? Yes / No
Has your child had a learning disorder? Yes / No
How many times has your child taken antibiotics? In last six months _____ During lifetime _____
How many doses of Prescription Medication has your child taken?
In last six months _____ During lifetime _____

My private health insurance is with _____ Covers Chiropractic? Yes / No
I understand that no accounts are rendered by this centre and my payment at the time of first visit will be:

☐ Cash ☐ Credit Card ☐ EFTPOS ☐ Cheque

Signed : _____ Print Name : _____