LANE COVE
CHIROPRACTIC

Child History Questionnaire

Date: ....

Please complete this detailed history form and return it to the Chiropractic Assistant at the Front Desk. Should you require any assistance please let us know as we will be happy to assist.

Child's Name: .... Date of Birth: ...../...../.....

Address: ....

.... Post Code: ....

Home Telephone: ....

Doctor's Name & Address: ....

Name of Previous Doctor of Chiropractic: ....

Date of Last Visit (dd/mm/yyyy): ...../...../.....

Child's Height .... cm Child's Weight .... kg

Name(s) of Parent(s) or Guardian(s): ....

Business/Mobile Telephone: ....

Who may we thank for referring you to this practice? ....

What are your chief concerns, if any, with your child's health?

....

....

List any other care that your child has undergone with regards to this complaint, including medication:

....

Date of onset (mm/yyyy): ....

The onset was (tick one): ☐ Sudden ☐ Gradual ☐ Associated with an event

Duration of problem/episode (tick one): ☐ Minutes ☐ Hours ☐ Days ☐ Months ☐ Years

Initiating Factors: ....

Aggravating Factors: ....

Relieving Factors: ....

How does the problem affect your child's body function and daily activities?

....

....

Prior occurrence or episodes? ....

Other health concerns?

....

....

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History of Birth

Hospital/Birthing Centre: ☐ Home ☐ Medical ☐ Midwife

Duration of Gestation: .... weeks

Was the birth assisted? ☐ Yes ☐ No

If yes, how? ☐ Forceps ☐ Vacuum Extraction ☐ Caesarean ☐ Induced Labour

Were medications given to the mother at birth? ☐ Yes ☐ No

If yes, what? ....

Duration of Birth: ....

Was the delivery normal? ☐ Yes ☐ No

If no, what complications occurred? ....

APGARs: .... Birth Weight: .... Birth Length: ....

Growth and Development

Was the infant alert and responsive within 12 hours of the delivery? ☐ Yes ☐ No

If no, explain: ....

At what age did the child:

Respond to sound: .... Follow an object: ....

Hold up head: .... Vocalize: ....

Sit alone: .... Teethe: ....

Crawl: .... Walk: ....

Do his/her sleeping patterns seem normal? ☐ Yes ☐ No

Describe any health problems that exist on mother's/father's side of the family (e.g. cancer, diabetes): ....

....

Does the child's siblings have any health problems? ☐ Yes ☐ No

If yes, describe: ....

The following information is very important because of the many problems that chiropractors work with are caused by stressors.

Chemical Stressors

During pregnancy, did the mother:

Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Take supplements/vitamins ☐ Yes ☐ No

Take drugs ☐ Yes ☐ No If yes, what? ....

Become ill ☐ Yes ☐ No If yes, what? ....

Receive ultrasounds ☐ Yes ☐ No If yes, how many? ....

Receive invasive procedures (i.e. amniocentesis, CVS) ☐ Yes ☐ No

Was your child breast fed? ☐ Yes ☐ No For how long? ....

As what age was:

Formula introduced: .... Brand: ....

Cow's milk: .... Solid Foods: ....

Did your child receive vaccinations? ☐ Yes ☐ No

If yes, which ones? ....

Did your child react to them? ☐ Yes ☐ No

Has your child had antibiotics? ☐ Yes ☐ No

If yes, why? ....

How many courses? ....

Any pets at home? ☐ Yes ☐ No

Any smokers at home? ☐ Yes ☐ No

Psychological Stressors

Any difficulties with lactation? ☐ Yes ☐ No

Any problems bonding? ☐ Yes ☐ No

Does the child have any behaviour problems? ☐ Yes ☐ No

If yes, what? ....

Does your child have difficulties sleeping? (e.g. night terrors, sleepwalking) ?

☐ Yes ☐ No

Did your child go to daycare? ☐ Yes ☐ No

If yes, from what age? ....

Average number of hours of TV/Computer per week? .... hours

Traumatic Stressors

Any evidence of following trauma during birth (tick):

☐ Bruises ☐ Odd shaped head

☐ Stuck in birth canal ☐ Fast/excessively long birth

☐ Respiratory Depression ☐ Cord Around neck

Other: ....

Any falls/accidents during pregnancy? ☐ Yes ☐ No

Has the child had any major falls since birth? ☐ Yes ☐ No

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If yes, did the child need stitches or cause a fracture? Please describe:

....

Any hospitalisation? ☐ Yes ☐ No If yes, please explain: ....

Does your child play sports? ☐ Yes ☐ No

If yes, how many hours per week? .... Age child began: .... years

Weight of school backpack? .... kgs

Approximately how many hours does your child spend at play per week?

.... hours

Please tick the boxes if your child has ever experienced, or is experiencing, the following:

☐ Headaches	☐ Visual Disorders	☐ Recurrent Tonsillitis
☐ Neck Pain	☐ Learning Difficulties	☐ Recurrent Chest Infections
☐ Back Pain	☐ Digestive Disorders	☐ Recurrent Stomach Aches
☐ Sinus Pain	☐ Asthma	☐ Hyperactivity
☐ Growing Pains	☐ Chronic Colds	☐ Constant Fatigue
☐ Join Pains	☐ Fevers	☐ Poor Co-ordination
☐ Arm/Leg Pain	☐ Earaches/Infections	☐ Scoliosis
☐ Constipation/Diarrhoea	☐ Seizures	☐ Bedwetting
☐ Loss of Appetite	☐ Allergies	☐ Hip Problems
☐ Travel Sickness		

All practitioners who adjust the spine are now required to warn of material risks pertaining to spinal adjustments. In extremely rare circumstances (less than 1 in 2 million) some spinal adjustments of the neck may damage a blood vessel and give rise to stroke-like symptoms. Whilst this has never occurred in this practice we are still required to warn. Other very slight risks with care include muscle strains and sprains and disk injuries. With these incidents full recovery is expected. Tests with or without x-rays will be performed to further minimize risk.

"The best evidence indicates that cervical manipulation for neck pain is much safer than the use of medication (non steroidal anti-inflammatory drugs) by as much as a factor of several hundred times".

Dabbs and Lauretti, JMPT, Oct 1995.

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Signed by the Parent/Guardian: ....

Print name: ....

Chiropractor's Signature: ....