



Welcome to Vida Chiropractic!

The purpose of this office is to help people get well and stay well.

Please take some time to complete all questions as thoroughly as possible so our team can assess how we can best help your child.

Child Health Questionnaire

Full Name:		Date:
Parents' Names:		
Address:		
Home Telephone:		Work Telephone:
Mobile Telephone:		Email Address:
Best Time/Place to Contact You:		
Date of Birth:	Age:	Gender: M / F
Do you have health insurance that covers Chiropractic care? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, name of fund:		
Are you a pension card holder? Yes <input type="checkbox"/> No <input type="checkbox"/>		Are you a student? Yes <input type="checkbox"/> No <input type="checkbox"/>

Who may we thank for referring you?

.....

Has your child ever received Chiropractic care before? If so, from whom? When? Were x-rays taken?

.....

.....

Please write your child's main health complaint:

.....

.....

What are your child's main interests/hobbies/sports:

.....

.....

Birth History

Hospital/Birthing Centre: Home Medical Midwife Doula

Gestation duration: _____ weeks

Was the birth vaginal? Yes No

Was the birth assisted? Yes No

If yes, how? Forceps Vacuum Planned C-section **or** Emergency C-section

Induced labour
 Assisted head turn/ traction

Was there any? Foetal distress Meconium staining Head presentation Face presentation Breech presentation

Birth History continued

Were any chemicals (medications) given to the mother during labour? Yes No

If yes, which ones?

Duration of labour:

Duration of pushing stage:

Was the delivery normal? Yes No

If no, what complications were there?

Did your child spend any time in intensive care? Yes No

If yes, how long?

APGAR at birth: APGAR at 5 minutes:

Birth weight: Birth length:

Growth and Development

Was your child alert and responsive within 12 hours of the delivery? Yes No

If no, explain:

At what age did your child: Hold up head? Sit alone?
Teethe? Crawl [conventionally]?
Walk?

Do his/her sleeping patterns seem normal? Yes No

How would you rate his/her quality of sleep? Good Fair Poor

Do the child's siblings have any health concerns? Yes No

If yes, please describe:

The following information is extremely important because many of the health concerns that Doctors of Chiropractic work with stem from lifestyle stressors.

Chemical Stressors

During the pregnancy, did the mother:

Smoke? Yes No

Drink alcohol? Yes No

Take vitamins/supplements? Yes No If yes, what?

Take recreational drugs? Yes No If yes, what?

Become ill? Yes No If yes, how?

Receive ultrasounds? Yes No If yes, how many?

Receive invasive procedures [eg.amniocentesis, CVS]? Yes No

Was the child breast-fed? Yes No

If yes, for how long? Weeks Months Years

At what age was:

• Formula introduced? Brand: Breast-fed only

• Cow's milk introduced?

• Solid food introduced?

Does the child have any food allergies? Yes No If yes, to what?

What does your child like to eat/ what is your child's favourite food?

What does your child regularly drink?

Chemical Stressors continued

Did your child receive any immunisations? Yes No

If yes: Full schedule Reduced schedule

What reactions did your child have to the immunisations? Fever Inconsolable crying Irritability Arching
 Bowel disturbances Feeding disturbances Drowsiness None recognised Other

How many courses of antibiotics has your child received in their lifetime?

When was the last course taken and why?

Any other chemicals [medications] in the last 6 months?

Rate your child's diet: Poor Good Excellent

Are there pets at home? Yes No

Are there any smokers at home? Yes No

Emotional Stressors

Did the child's mother have any difficulties with breast-feeding? Yes No

Did the child's mother and the child have any difficulty bonding? Yes No

Does your child have any behaviour issues? Yes No If yes, what:

Does your child have difficulty sleeping [eg. nightmares, sleepwalking, insomnia]? Yes No

If yes, please specify:

Does your child attend daycare? No Yes If yes, from what age:

Average time spent at computer/watching television each week: hours

Is your child nervous or has anyone suggested that your child was nervous? Yes No

Rate your child's level of stress [stress may be brought on by factors such as moving house/school, divorce, losing a family member]:
 LOW 1 2 3 4 5 6 7 8 9 10 HIGH

Physical Stressors

Was there any evidence of trauma from the birth? Bruising Odd shaped head Respiratory distress
 Stuck in birth canal Fast or excessively long birth Cord around neck Other

Was there any falls/accidents during the pregnancy? Yes No

If yes, please describe:

Has the child had any falls since birth? Yes No

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

Has the child ever been hospitalised? Yes No

If yes, why?

Has your child ever been involved in a motor vehicle accident? Yes No

Does your child play sport/exercise regularly? Yes No If yes, number of hours per week:

At what age did your child begin sport/exercising regularly?

Weight of school backpack? gms/kgs

How would you rate your child's posture?
 POOR 1 2 3 4 5 6 7 8 9 10 EXCELLENT

Approximate hours spent at play per week? hours

Does your child have difficulty with co-ordination? Yes No

Your Child's Symptoms

Please mark the following conditions you may have had or have now:

Low back pain <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Neck pain <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Digestive troubles <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Asthma <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Headaches <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Allergies <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition
Sleeping disorders <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Cold/flu <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Ear/throat infections <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Breathing problems <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Fatigue <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Irritability <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition

Your Child's Symptoms continued

Hyperactivity <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Bloody nose <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Meningitis <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Diarrhoea <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Constipation <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Bed wetting <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition
Rashes <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Milk or lactose intolerance <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Sinus problems <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Loss of hearing <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Learning disorders <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	Other <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition

Other (please explain)

.....

.....

If you could improve one aspect of your child's health or behaviour, what would it be?

.....

.....

.....

Informed Consent

There are many concerns about the safety of procedures we undergo routinely, the environment we live in, and the food we consume but to name a few. We hope to explain some of the risks and common responses to chiropractic care so that any concerns on these matters may be eased. We hope that having a better understanding of the care you will receive at Vida Chiropractic will enhance your experience.

Most people will experience some level of discomfort in the early stages of care. This is due to the change in the pattern of the nervous system. It is a normal response during the initial phase of care.

If you are (or have been) taking anticoagulant (blood thinning) medication or steroids then it is important to tell your chiropractor this prior to commencing care.

There are always risks associated with any therapeutic intervention! Regarding manual spinal adjustment, the risk of permanent injury or death is approximately 1 in 2,500,000. To place this in perspective, the risk of death from gastric bleeding when taking an aspirin or Paracetamol for aches and pains is approximately 3 in 1000. Statistically there is more chance of being hit by lightning than experiencing permanent damage or dying from a manual adjustment.

We must explain these risks to you so that you can make an informed decision about commencing, or continuing your care. If you have any further concerns please ask your chiropractor.

The adjustments and care you receive here at Vida Chiropractic will be tailored to your specific needs. In all cases we attempt to provide care in as gentle a fashion as possible. Our range of techniques provide for almost any person, age or condition. If at any stage of your care you have concerns, doubts or questions we encourage you to discuss these matters with your practitioner.

When you refer friends and family to see us for chiropractic care, we like to recognise your trust and confidence in us by acknowledging you on a notice. Please let us know if you would prefer not to be thanked publicly.

I have read the above and give authority to Vida Chiropractic to commence/continue chiropractic care for either myself or my dependent. (whichever is applicable)

Signed:

Name (please print):

Witness:



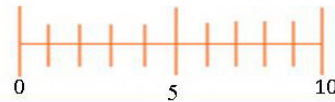
Child Health Summary

Name: _____

Date: _____

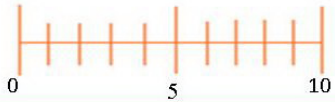
Assessment Number: 1 2 3 4

Chief Concern:



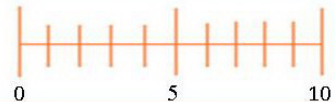
My child's flexibility in their neck is:

0= Flexible, 10 = Rigid



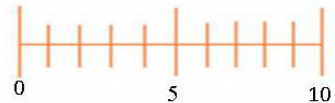
My child's flexibility in their mid back is:

0= Flexible, 10 = Rigid



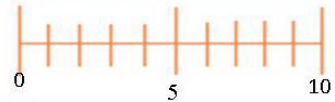
My child's flexibility in their low back is:

0= Flexible, 10 = Rigid



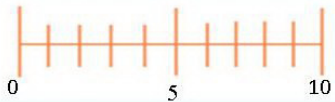
My child's energy level seem:

0= High, 10 = Low



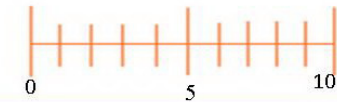
My child's posture seems:

0= Great, 10 = Bad



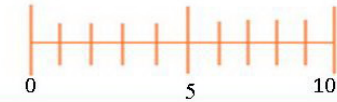
My child's mood seems:

0= Great, 10 = Bad



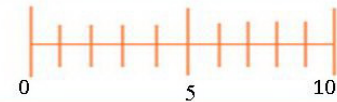
My child's sleep duration and quality are:

0= Great, 10 = Bad



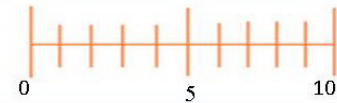
My child's concentration seems:

0= Great, 10 = Bad



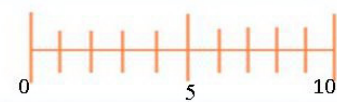
My child's immune system function seems:

0= Great, 10 = Bad



My child's co-ordination is:

0= Great, 10 = Bad



My child's digestive function is:

0= Great, 10 = Bad

