



Vida Chiropractic  
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## Welcome to Vida Chiropractic!

### Child Health Questionnaire

Full name:		Date:
Parent's names:		
Address:		
Home phone:	Work phone:	
Mobile phone:	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?

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Has your child ever received chiropractic care before? If so, from whom? And when? Were x-rays taken?

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Please write your child's main health complaint:

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### At the Child's Birth:

Was the birth chemically induced?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Was a doctor's assistance required?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Was a Caesarian Section performed?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Were forceps used?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did the Doctor have hands on the infant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Was the mother lying down?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Was a family member present. If so, who?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Was the baby premature? If so, what was his / her weight?	Yes <input type="checkbox"/> No <input type="checkbox"/>

## Your Child's Symptoms

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

<b>Low back pain</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Neck pain</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Digestive troubles</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Asthma</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Headaches</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Allergies</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition
<b>Sleeping disorders</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Cold/flu</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Ear/throat infections</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Breathing problems</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Fatigue</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Irritability</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition
<b>Hyperactivity</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Bloody nose</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Meningitis</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Diarrhoea</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Constipation</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Bed wetting</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition
<b>Rashes</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Milk or lactose intolerance</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Sinus Problems</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Loss of hearing</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Other</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition	<b>Other</b> <input type="checkbox"/> Current condition <input type="checkbox"/> Past condition

Other (please explain) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is your child accident prone?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has the child had any falls down steps?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has your child ever fallen from heights over 2 feet?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has your child ever been involved in a motor vehicle accident?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has your child ever been hospitalized or had surgery?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has your child ever had any broken bones or sprain injuries?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is your child on medication?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has your child had a spinal curvature (scoliosis) examination by an approved scoliosis determination procedures clinic?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child have a learning disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child have poor posture?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is your child nervous, or has anyone suggested that your child was nervous?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child show any signs of nervousness, twitching or excessive talking to themselves?	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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# 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: \_\_\_\_\_