Naturopathic Initial Child Consult Form

To provide you with the best quality care, we ask that you complete the following as accurately and honestly as possible. This form is a PDF document that you can simply type your answers into, print or save as a PDF again and email back to admin@yerongachiropractic.com.au at your earliest convenience. Thank you!

Date of Initial Consultation:

Child's full name:

Date of Birth: Age: Sex: Male ☐ Female ☐ Other ☐

Address:

Phone Number:

Email:

(By providing this information I give permission to be contacted by Yeronga Chiropractic & Wellness)

Emergency Contact:

Relationship to patient: Contact No.:

How did you find out about us?

CURRENT HEALTH CARE TEAM

General Practitioner:

Clinic: Contact No.:

Specialist Physician:

Specialty: Contact No.:

Other Health Care Team Members (eg. Chiropractor, osteopath, acupuncturist)

Practitioners Name:

Modality: Clinic Name:

REASON FOR VISIT / PRESENTING ISSUES?

Please be specific and in order of importance to your child.

1.

2.

3.

PERSONAL MEDICAL HISTORY

Pregnancy/Birth **Please list any problems**	
Developmental milestones **Please list any problems**	
Illnesses since birth	
Surgery **Please List**	
Traumatic events affecting health	

MEDICATIONS AND SUPPLEMENTS

Please include the medications your child takes regularly including pharmaceuticals e.g. panadol/neurofen, vitamins, supplements, herbal or homeopathic remedies. Include past medications e.g. anti-depressants etc.

Medication and dose	Current or Past	Prescribed or self-prescribed	Frequency	Reason	How long	Were they effective

FAMILY HISTORY

Please include diagnosed mental or physical health conditions from parents, siblings, maternal and parental grandparents eg. anxiety, depression, heart disease, diabetes, thyroid disease, asthma etc.

Relationship	Condition(s)	Age

GENERAL HEALTH QUESTIONNAIRE

CURRENT HEALTH STATUS

How would you rate your child's current health?
1 = very poor *10 = perfect health*

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

How would you rate your child's current energy levels?
1 = no energy, can't get out of bed *10 = bursting with energy*

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

How would you rate your child's current stress levels?
1 = no stress *10 = extremely stressed*

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Height (cm): Weight (kg):

Last visit to a GP: Reason:

Date of last blood tests:

SLEEP

Average hours of sleep per night:

What time does your child go to bed on average?

What time do they wake on average?

Does your child ever experience the following? *(Please tick)*

☐ Insomnia ☐ Difficulty falling asleep ☐ Difficulty waking ☐ Difficulty staying asleep
☐ Snoring ☐ Sleep walking ☐ Night sweats ☐ Bad dreams
☐ No dreams ☐ Daytime napping ☐ Excessive sleep (10+ hours per night)

MENTAL / EMOTIONAL HEALTH

What causes your child stress *(e.g. sensitivities to light/sounds, school)?*

Does your child ever experience the following? *(Please tick)*

- ☐ Palpitations
- ☐ Depression
- ☐ Mood swings
- ☐ High stress levels
- ☐ No motivation
- ☐ Addictive tendencies
- ☐ Poor concentration
- ☐ Excessive worrying
- ☐ Panic attacks
- ☐ Poor memory
- ☐ Feelings of overwhelm or unable to cope

DIGESTION

How often does your child pass a bowel motion? _____

Does your child have any food intolerances/allergies? ☐ Yes ☐ No

(If yes give details) _____

Does your child ever experience the following? *(Please tick)*

- ☐ Loose stools
- ☐ Hard stools
- ☐ Difficulty passing a stool
- ☐ Nausea
- ☐ Blood in stools
- ☐ Excessive flatulence
- ☐ Undigested food in stools
- ☐ Burping
- ☐ Bloating
- ☐ Heartburn/reflux
- ☐ Abdominal pain
- ☐ Parasites
- ☐ Vomiting
- ☐ Abnormal thirst
- ☐ Difficulty swallowing
- ☐ Bad breath
- ☐ Burning anus
- ☐ Itchy anus
- ☐ Excessive wind/gas
- ☐ Crave sweet foods in the afternoon

Other: _____

IMMUNE/RESPIRATORY

How many colds does your child get per year? _____

How long does it usually take them to recover? _____

Are your child's vaccinations up to date? ☐ Yes ☐ No

Past infections e.g glandular fever/ Herpes simplex virus/ chicken pox/ Strep throat/ UTI's? _____

Does your child ever experience the following? *(Please tick)*

- ☐ Low resilience
- ☐ Mouth ulcers
- ☐ Persistent cough
- ☐ Allergies
- ☐ Post nasal drip
- ☐ Sinus congestion/inflammation

In your child's lifetime, how many courses of antibiotics have they received?

- ☐ 0 – 4
- ☐ 5 – 9
- ☐ 10 – 14
- ☐ 15+

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Muscle aches
- ☐ Headaches
- ☐ Joint stiffness after rising
- ☐ Muscle cramps

DIET

Does your child follow a particular diet?
(eg: vegan, vegetarian, FODMAPs)

How long for?

Water per day: ml. Tap/bottled/filtered/rainwater:

Breast feed: times/day.

Bottle feed: bottles/day. Type:

Others: fruit juice/soft drinks/sport drinks/milk drinks: How many glasses per day?

Please provide an outline of your child's typical diet *(be as accurate & honest as possible – no judgement here folks!)*

Breakfast		Time:
Snacks		Time:
Lunch		Time:
Snacks		Time:
Dinner		Time:
Snacks		Time:

Cravings (sweets, salt, pastries, fried foods, chocolate etc.) Aversions / Dislikes

Does your child have an appetite in the morning? ☐ Yes ☐ No

Is your child a fussy eater? ☐ Yes ☐ No

Does your child sit to eat without distractions? ☐ Yes ☐ No

How often does your child eat takeaway?

Please list any other information you feel is relevant below:

This information is collected for clinical and contact purposes only.

Please email this questionnaire along with any other relevant documents, eg. pathology results, to **admin@yerongachiropractic.com.au** as soon as possible.

Thank you for taking the time to complete this form

Melissa Le Breton – Naturopath

yeronga chiropractic & wellness centre