yeronga chiropractic & wellness centre

New Child Patient Questionnaire (Infant to 5yrs)

Personal Details

Child's name:	Parent Names Parent 1: Parent 2:	Date:
Address:		
Suburb/Town:		Post Code:
Date of Birth:	Gender:	
Parent's Phone:	Email:	
Regular GP/ Paediatrician Details:		
Keeping in touch. Please confirm the way you would like to be contacted by us: ☐ SMS ☐ Email		

Referrals

How were you referred to our clinic?

☐ Friend/family member	If so – Name:	
☐ Other health professional/Chiropractor	If so – Name:	
☐ Internet		
☐ Spinal Screening		
☐ Signage		
☐ Advertising		

History

What concerns do you have regarding the health of your child?

When did the symptoms start?

What makes the symptoms better?

What makes the symptoms worse?

Are they getting worse? ☐ Yes ☐ No

Has this occurred before? ☐ Yes ☐ No

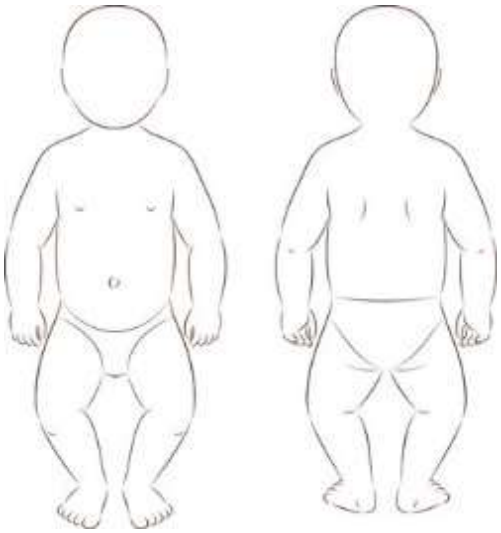
How often does this occur?

Do you know what caused it?

Has your child received any treatment for this condition? If so, please list:

Was it effective? ☐ Yes ☐ No

Please indicate the area(s) of discomfort on the diagram (on right)



Pregnancy

How was your child conceived? ☐ Naturally ☐ IVF/IUI ☐ Other:

Did you have any complications during pregnancy? ☐ Yes ☐ No

If yes, please explain:

Did you take any medication during pregnancy? ☐ Yes ☐ No

Number of pregnancies?

Did you take a prenatal supplement? If yes, please list

Were there any concerns with your child's position in-utero?

Were there any concerns with your child's growth?

Birth

At what gestational age did you give birth?

How was your child delivered? (please tick the appropriate box)

☐ Premature ☐ Forceps ☐ Without intervention

☐ Late ☐ Caesarean ☐ Chemically induced

☐ At term ☐ Suction ☐ Vacuum or other

Do you believe the birth was traumatic for your child? ☐ Yes ☐ No

Were there any delivery complications? ☐ Yes ☐ No

If yes, please explain:

Did your child receive vitamin K injection? ☐ Yes ☐ No

Please state your child's APGAR scores at birth if known:

BIRTH TO SIX MONTHS

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

Was your child formula fed? ☐ Yes ☐ No For how long and what brand?

Was your child formula fed in the first three days of life? ☐ Yes ☐ No

Did you child suffer Colic/Reflux ☐ Yes ☐ No

Please rate your child's sleeping

☐ Very Poor ☐ Poor ☐ Average ☐ Good ☐ Very Good

General History

Has your child had any significant falls of injuries?	☐ Yes	☐ No	
Has your child ever been in a motor vehicle accident?	☐ Yes	☐ No	
Has your child been hospitalised or had surgery?	☐ Yes	☐ No	
Has your child suffered any significant illnesses?	☐ Yes	☐ No	
Is your child on any medication? Please list	☐ Yes	☐ No	
Has your child received all their immunisations?	☐ Yes	☐ No	

What age did your child crawl?

What age did your child walk?

From early life to present, have there been any concerns with (please tick condition/s):

☐ Birth Complications (difficult/traumatic)	☐ Colic/unsettled baby	☐ Reflux	☐ Constipation/diarrhoea	☐ Fever/nausea
☐ Tinnitus/Ringing in ears	☐ Sleeping	☐ Breastfeeding	☐ Mobility	☐ Flexibility
☐ Muscle weakness	☐ Coordination	☐ Posture	☐ Scoliosis	☐ School work
☐ Double/blurred vision	☐ Tingling/numbness	☐ Asthma/breathing difficulties	☐ Cold/painful extremities	☐ Dizziness/loss of balance
☐ Painful cough/sneeze	☐ Muscle tone	☐ Sport injuries	☐ Weight or growth issues	

Have you had any concerns regarding your child's development, injuries or illness during the years of:
(please tick and briefly outline)

☐ 0-1 years of age	
☐ 1-5 years of age	

Do you have any other questions or concerns that you would like to discuss?

Thank you for taking the time to fill out this form

Informed Consent to Chiropractic Care

As with any health care physical examination and/or care provided support there is a risk (however small) of a condition changing or an adverse outcome from the treatment. Recent evidence has demonstrated that no serious adverse events have been reported in association with chiropractic care since 1992, and no deaths from paediatric chiropractic care has ever been reported (Todd et al., 2015).

Research by the International Chiropractic Paediatric Association in 2009 deemed chiropractic care to be safe for children, with less than 1% experiencing minor discomfort post-treatment, which resolved with continued care (Alcantara et al., 2009). Doctors and parents reported high improvement rates with respect to children presenting complaints.

If you have any questions related to the treatment your child may receive, please speak to your chiropractor.

I acknowledge that I am aware of and understand the potential risks. I have discussed the above information with the treating chiropractor and give my consent for treatment to be provided to my child. I understand that results are not guaranteed and that the chiropractor is not able to anticipate all potential risks and complications associated with the proposed care.

I acknowledge that my chiropractor will use specific chiropractic techniques suitable for my child's age and presenting symptoms to ensure safe care is provided. I have had the opportunity to ask questions about the nature, extent and purpose of the proposed chiropractic care and I have been given sufficient time to make a decision giving consent for the care to proceed. I intend this consent form to cover the entire course of treatment for my present condition and for any other future condition(s) for which I seek treatment by Yeronga Chiropractic and Wellness Centre. I understand that I can withdraw my consent at any time.

Please do not sign until you have spoken to your Chiropractor.

Date:	
Patient/Guardian Name:	
Parent/Guardian Signature:	
Chiropractor's Signature:	

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