Confidential Case History - Child

CHOICE CHIROPRACTIC

changing spines, changing lives...

www.choicechiropractic.com.au

For us to understand your child's health problem we need a complete history of his/her present and previous symptoms and treatment.

Surname: _____ Childs Name:_____ Parents Name:_____

Address : _____ Post Code: _____

Phone: Work _____ (hours _____ to _____ Home: _____

Sex: Male / Female Date of Birth: _____ / _____ / 19 _____ Age: _____

What health fund do you belong to _____

Does it cover Chiropractic? Yes / No

Has your child been treated by a chiropractor before? Yes / No

If yes, for what condition ? _____

Were X - Rays taken? Yes / No

Has your child ever suffered any injury or serious illness? Yes / No

If yes, please specify _____

At the Child's Birth: -

Was it chemically induced? Yes / No

Was Doctor assistance required? Yes / No

Was a C - Section performed? Yes / No

Were forceps used? Yes / No

Did the Doctor have hands on the infant? Yes / No

Was the Mother lying down? Yes / No

Was a family member present Yes / No

If yes, who? _____

(Note** 95% of all infants were born with hands or forceps delivery)

Was the baby premature? Yes / No

If so, what was his / her weight? _____

How did you find out about this practice ?

Friend ❒ Family Member ❒ Yellow pages ❒ Other ❒ Referred by : _____

The childs symptoms in the past 6 months

Tick off any of the following symptoms your child has experienced in the past 6 months.

____ LOW BACK PAIN
____ DIGESTIVE TROUBLES
____ HEADACHES
____ SLEEPING DISORDERS
____ EAR / THROAT INFECTIONS
____ FATIGUE
____ HYPERACTIVITY
____ MENINGITIS
____ CONSTIPATION
____ RASHES
____ MILK OR LACTOSE INTOLERANCE
____ LOSS OF HEARING
____ NECK PAIN
____ ASTHMA
____ ALLERGIES
____ COLD / FLUx
____ BREATHING PROBLEMS
____ IRRITABILITY
____ BLOODY NOSES
____ DIARRHEA
____ BED WETTING
____ COLIC
____ SINUS PROBLEMS

OTHERS _____

The child's current condition:

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

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

Signature of Guardian / Parent

_____ Date _____/_____/20_____