CONFIDENTIAL PAEDIATRIC/CHILD FORM

Name:	**Today's Date:**
What Do You Prefer to be Called:	
Parents'/Guardian's Names:	
Parents' Marital Status: □ Married □ Single □ Widowed □Divorced	
Home Phone:	**Parent's Mobile:**
Mailing Address:	**Town:** **Post Code:**
Child's Birth Date: **Age:**	**Sex: □ Male □ Female** **Name of GP:**
Parent's Email Address:	
How did you learn about our clinic?	
Previous Chiropractic Care? □ Yes □ No	**Approximate Last Visit Date:**

Please check reasons for pursuing chiropractic care for your child:

____ He/She is continuing ongoing care from another chiropractor.

____ I recently had my spine checked and see the value in getting my child checked.

____ I'm concerned about his/her health and I'm looking for answers.

____ I want to improve my child's immune function.

____ I have no idea why we're here. Please take the time to explain to me what you do for children.

____ He/She has a specific condition that concerns me.

Explain condition or symptom:

_____

_____

_____

Please list any previous and/or current chronic health diagnosis that he/she has been given:

_____

_____

_____

If he/she takes prescription medications, please let us know the conditions for which he/she takes the medication & the name of medication if possible.

_____

Number of doses of antibiotics your child has taken:

During the past 6 months: _____

Total during his/her lifetime: _____

List reasons: _____

Number of doses of other prescription medications your child has taken:

During the past 6 months: _____

Total during his/her lifetime: _____

List reasons: _____

Prenatal History:

Adopted □ Yes □ No

Complications during pregnancy? □ Yes □ No

List reasons: _____

Ultrasounds during pregnancy? □ Yes □ No Number: _____

Medications/drugs/caffeine use during pregnancy? □ Yes □ No

List: _____

Cigarette/Alcohol use during pregnancy? □ Yes □ No

Location of birth: □ Hospital □ Birthing Center □ Home

Birth Intervention:

□ Mother Induced □ Mother medicated (Pitocin, etc.) □ Caesarian Section

□ Forceps □ Vacuum Extracted □ Baby given medication after delivery

Complications during delivery? □ Yes □ No List:_____

Genetic Disorders or Disabilities? □ Yes □ No List:_____

Breast Fed? □ Yes □ No How Long? _____ Formula Fed? □ Yes □ No How Long? _____

Food or Other Allergies? □ Yes □ No List: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ex. A bed, changing table, down stairs, etc.). Was this the case with your child? □ Yes □ No List: _____

Is/Has your child been involved in any high-impact or contact-type sports (e.g. football, rugby, gymnastics, hockey, basketball, martial arts, etc.)?

□ Yes □ No List: _____

Has your child been seen in an emergency room?

□ Yes □ No List: _____

Prior surgery? □ Yes □ No List: _____

Consent to Examination

I consent to a professional and complete chiropractic examination and any other relevant tests that the doctor of chiropractic deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

For children under 16 years of age, or persons of diminished intellectual capacity, this consent should be signed by a parent or legal guardian below.

Print Patient Name: _____

Signature: _____

Date: _____