Living Well CHIROPRACTIC Coffs Harbour

HEALTH IN PARTNERSHIP

CHILD HISTORY QUESTIONNAIRE

Phone: 02 6651 3901

ACN: 163289405

Child's Name ____

Date of Birth ____/____/____ School ______________________________

Address ____

Suburb ______________________________ Post Code __________

Phone (H) ___________________ (M) ______________________

Name(s) Parent(s) or Guardian(s) ______________________________

Contact phone (if different to above) _____________________

Does the family have a Centrelink health care card? ☐ Yes ☐ No

Doctor's Name __________________________

Has the child seen a chiropractor before? ☐ Yes ☐ No

If yes, name of Chiropractor and last treatment date __________________

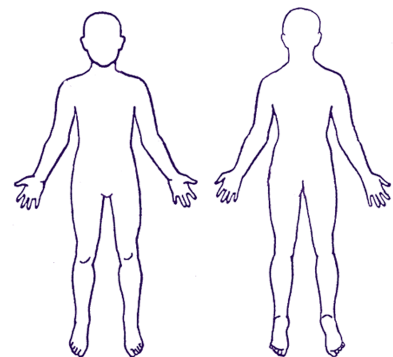
Child's Height (cm) _________Weight (kg) __________

Private health cover _________________________

Who may we thank for referring you to this Practice

____

Please use the diagram to indicate any areas of concern on your child's body



What is your main Area of Concern with your child's health?

____

____

When did this problem start, date of onset (mm/yyyy)?

____

The onset was (tick one) ☐ Sudden ☐ Gradual ☐ Associated with an event

Do you know what caused the problem? ______________________________

What makes it better? ____

What makes it worse? ____

Duration of problem/episode e.g. minutes/hours/days______________________

Have you had any previous treatment for this problem? ☐ Yes ☐ No

Did it work? ____

How does the problem affect your child's function and daily activities? _____________

____

Any prior occurrences or episodes? ________________________________

Other health concerns? ______________________________________

Health History

Infancy and Early Childhood

Did your child experience a difficult or traumatic birth (premature, overdue, long labour, forceps, ventouse, c-section etc)? Please detail____
____
Was your baby irritable, colicky or hard to settle?____
____
Did your baby experience feeding issues (breastfeeding problems, intolerances, allergies, reflux, failure to thrive)?____
Please list any concerns regarding your child's early development or reaching of milestones (eg. rolling over, crawling, walking, co-ordination, speech, interaction with others)?______________________________
____

Please TICK the boxes if your child has ever experienced, or is experiencing, the following:

- ☐ Headaches/migraines
- ☐ Neck pain
- ☐ Back pain
- ☐ Sinus pain
- ☐ Growing pains
- ☐ Joint problems
- ☐ Arm/leg pain
- ☐ Digestive issues
- ☐ Skin problems
- ☐ Travel sickness
- ☐ Visual Disorders
- ☐ Hearing problems
- ☐ Learning Difficulties
- ☐ Asthma
- ☐ Chronic Colds
- ☐ Fevers
- ☐ Earaches/infections
- ☐ Seizures
- ☐ Allergies
- ☐ Poor fine motor skills
- ☐ Recurrent tonsillitis
- ☐ Recurrent chest infections
- ☐ Bedwetting
- ☐ Hyperactivity
- ☐ Constant fatigue
- ☐ Poor Co-ordination
- ☐ Scoliosis
- ☐ Painful periods
- ☐ Mood swings
- ☐ Sensory issues

List any other major conditions (past or present)____
____
____

Please provide details of any health problems that run in your family:
____
____

Chiropractic care will help to release tension from your child's spine, nervous system and body. Tensions build up because of physical, emotional and chemical stresses. The following information is important because it will help us to understand the stresses your child has experienced up until now.

Physical Stress

Please list your any major accidents or injuries (sprains, strains, fractures, stitches)?

____

____

Please detail any times your child has had surgery or been hospitalised_______________________________

____

What sports, activities and hobbies does your child participate in?

____

____

How much screen time (TV, hand-held devices, computer use) would your child have per day? __________

Do you have concerns for your child's posture? YES NO

Is your child in the healthy weight range? YES NO

How heavy is your child's backpack? ____

Chemical Stress

Was your child exposed to alcohol, smoking, drugs or medications during pregnancy? _________________

____

How long was your child breastfed?____

Please list any adverse reactions to medications (including vaccinations)?_____________________________

____

How many courses of antibiotics has you child had and for what conditions?

____

____

How much processed or packaged food would your child eat or drink on a typical day? (please list)

____

____

How much water does your child drink daily? ____

Is your child exposed to second hand smoke? YES / NO

Please list any allergies or intolerances that your child has?_______________________________________

____

Please list any medications or supplements that your child takes?

____

____

Psychological Stressors

List stressful life events that your child has been exposed to? Eg. family fighting, separation, illness of loved one, loss of a family member or friend? ____

____

Is your child happy at school and at home?____

List any difficulties your child is having with learning? ____

____

List any concerns you have about your child's behaviour?____

____

Has your child experienced social issues or bullying? ____

Does your child have difficulty sleeping (eg, getting to sleep, night terrors, nightmares, sleepwalking)?

____

Please list any other concerns you have for your child's mental well-being?

____

____

Is there anything else about your child's health or life circumstances that you think may be relevant?

____

____

All practitioners who adjust the spine are now required to warn of the material risks pertaining to spinal adjustment. In extremely rare circumstances (less than 1 in 2 million) some spinal adjustments of the neck may damage a blood vessel and give rise to stroke-like symptoms. Whilst this has never occurred in this practice we are required to warn. Other very slight risks with care include strains, sprains and disc injuries. With these incidents full recovery is expected. Tests with or without x-rays will be performed to further minimize risk.

The best evidence is that cervical manipulation for the neck pain is much safer than the use of medication (non steroidal anti- inflammatory drugs) by as much as a factor of several hundred times.
Dabbs and Lauretti, JMPT, Oct 1995.

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Signed by the Parent/Guardian: ________________________________ Date _____/_____/____

Print Name: ____

Chiropractor's signature: ______________________________________ Date ____/____/____

Thank you for your time and patience in filling out your child's health questionnaire.