Black Rock
CHIROPRACTIC CENTRE

CONFIDENTIAL PATIENT INFORMATION

In order to provide your child with the best possible care, please complete the following.

Date:…….....

Child's Name:……

Birthdate:…… Age:……...

Address:……. Postcode……

Ph. Home: (….) …… Mobile contact: ……...

Contact Email Address:……

Siblings:…….Age: …….....

Parent / Guardian's Name: ……..

How did you find out about our clinic?:……

Has your child ever received Chiropractic care? Yes □ No □

If Yes, from whom?…… When?.....

Is your child covered by a health fund that includes chiropractic?.....

Which fund?.....

Your child's GP is: Dr……Phone……..

Address:…….

Presenting complaint

What are your chief concerns, if any, with your child's health, and what is the main reason for your child's visit? …….

List any other care your child has undergone with regards to this concern (including medications):……..

Date and duration of onset:……

Was onset sudden/gradual or related to a specific event?.....

What aggravates this complaint:…….....

What relieves this complaint:…….

Previous episodes:……..

Other health concerns:……...

Birth History

	YES	NO
Pregnancy		
Did your child's mother . . .		
Have Chiropractic care during pregnancy	☐	☐
Exercise through pregnancy	☐	☐
Have a nutritious diet during pregnancy	☐	☐
Get injured during pregnancy	☐	☐
Smoke or drink alcohol during pregnancy	☐	☐
Take any drugs (recreational or prescription)?	☐	☐
If yes, what ones?.....		
Endure stress during pregnancy	☐	☐
Take vitamins/supplements?	☐	☐
If yes, what ones?.....		

Birth Process

Was your child born in a hospital?	□	□
Was the birth early/late?	□	□
Was the birth induced ?	□	□
Was the delivery long ?	□	□
Did the delivery require forceps/suction?	□	□
Was the birth Caesarean (Elective / Emergency)?	□	□
Was the birth breech?	□	□
Were any medications given during labour?	□	□
If yes, which ones?.....		
Were there any complications during the birth?	□	□
Please list …….		
APGAR at birth:……. APGAR at 5 mins:…….		
Birth weight:…… Birth length: …….		

Growth and Development

Was your child you breast fed?	□	□
If yes, for how long? …….		
Has your child ever fallen on its head?	□	□
Had any other major falls?	□	□
Do his/her sleeping patterns seem normal	□	□
Does your child have a balanced diet?	□	□
Is your child a fussy eater?	□	□
Does your child wear glasses or contact lenses?	□	□
Does your child have difficulty with coordination?	□	□

At what age did your child: Crawl?..... Walk?.....

Has your child had any accidents?:……..

Has your child had any surgery? :……

Is your child currently taking any medication?.....

Has your child been immunised?.....

Does your child have any behavioural issues?.....

Does your child have any allergies?……..

Does your child participate in any sport? Please list…….

Average time spent at computer/TV per week? ……. (hrs)

Do any health conditions exist on the mother's or father's side (e.g. cancer, diabetes etc.)? Please describe:……

Do the sibling's have any health concerns?……..
……

***Please sign*:**
I hereby authorize and consent to the chiropractic health evaluation and care of my child.

Parent/ Guardian signature:……..

Witness:…….

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