Welcome to Vitality Chiropractic!

The purpose of this office is to help people get well and stay well.

Please take some time to complete all questions as thoroughly as possible so our team can assess how we can best help your child.

Child Health Questionnaire

Full Name:	**Date:**	
Parents' Names:		
Address:		
Home Telephone:	**Work Telephone:**	
Mobile Telephone:	**Email Address:**	
Best Time/Place to Contact You:		
Date of Birth:	**Age:**	**Gender: M / F**

Who may we thank for referring you?

.....

Present Health Concerns

Please tick the purpose for your child's visit:

☐ Crisis Management ☐ Early detection of problems ☐ Prevention ☐ Wellness ☐ Maximising brain growth & development

☐ Other.....

.....

Has your child ever received Chiropractic care before? ☐Yes ☐No If so, from whom? When?

.....

Has your child seen any other health care providers for this condition? ☐Yes ☐No If yes, whom? When?.....

.....

What are your child's main interests/hobbies/sports?

.....

Your Child's Symptoms

Please mark below anything that your child may have had or is currently experiencing:

Many parents bring their children to our practice to enhance their wellbeing. If your child has no symptoms or complaints and you are here for wellness, please turn to page 2.

Low back pain ☐Currently ☐In past	**Neck pain** ☐Currently ☐In past	**Digestive troubles** ☐Currently ☐In past	**Asthma** ☐Currently ☐In past	**Headaches** ☐Currently ☐In past	**Allergies** ☐Currently ☐In past
Sleeping disorders ☐Currently ☐In past	**Cold/flu** ☐Currently ☐In past	**Ear/throat infections** ☐Currently ☐In past	**Breathing problems** ☐Currently ☐In past	**Fatigue** ☐Currently ☐In past	**Irritability** ☐Currently ☐In past
Hyperactivity ☐Currently ☐In past	**Bloody nose** ☐Currently ☐In past	**Meningitis** ☐Currently ☐In past	**Diarrhoea** ☐ Currently ☐In past	**Constipation** ☐Currently ☐In past	**Bed wetting** ☐Currently ☐In past
Rashes ☐Currently ☐In past	**Milk or lactose intolerance** ☐Currently ☐ In past	**Sinus problems** ☐ Currently ☐In past	**Loss of hearing** ☐Currently ☐In past	**Learning disorders** ☐Currently ☐In past	**Other** ☐Currently ☐In past

Other (please explain) .....

.....

Birth History

Was your child's birth: ☐Birthing Centre: ☐Home ☐ Hospital ☐ Other_____

What was your child's gestational age at birth? _____weeks

Was the birth vaginal? ☐Yes ☐ No

Was the birth assisted? ☐Yes ☐No

If yes, how? ☐ Forceps

☐ Vacuum

☐ Planned C-section **or** ☐ Emergency C-section

☐ Induced labour

☐ Assisted head turn/ traction

Was there any? ☐ Foetal distress

☐ Meconium staining

☐ Head presentation

☐ Face presentation

☐ Breech presentation

Was labour: ☐Spontaneous ☐Induced

Were medications or epidurals given to the mother during birth? ☐ Yes ☐ No

If yes, which ones? _____

Duration of labour _____Duration of pushing stage:_____

Was the delivery normal? ☐ Yes ☐ No

If no, what complications were there?_____

Did your child spend any time in intensive care? ☐ Yes ☐ No. If yes, how long? _____

APGAR at birth: _____/10 APGAR at 5 minutes: _____/10

Birth weight: _____ Birth length:_____

Were any medications given to your baby at birth? (e.g. antibiotics) ☐ Yes ☐ No

Growth and Development

Was your child alert and responsive within 12 hours of the delivery? ☐ Yes ☐ No

If no, explain: _____

At what age did your child: Hold up head? _____ Sit unassisted? (5-7 months)_____

Cut first tooth?_____ Crawl [on all fours]?(8-10 months) _____

Walk? (11-15 months) _____

Do you feel that your child is developing as they should compared to other children of the same age? ☐Yes ☐ No

Do you have any concerns about your child's: ☐ Hearing ☐ Vision ☐ Balance ☐ Co-ordination ☐ Headshape

☐Other_____

Do his/her sleeping patterns seem normal? ☐ Yes ☐ No How many hours per day?_____

How would you rate his/her quality of sleep? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What position does your child sleep in? ☐ Back: ☐ Side: ☐ Front:

Do the child's siblings have any health concerns? ☐ No ☐ Yes

If yes, please describe:_____

The following information is extremely important because many of the health concerns that Chiropractors work with stem from lifestyle stressors.

Emotional Stressors

Was the mother stressed during the pregnancy? ☐ No ☐ Yes. Comment (if required)_____

Did the child's mother have any difficulties with breast-feeding? ☐ Yes ☐ No

Did the child's mother and the child have any difficulty bonding? ☐ Yes ☐ No

Does your child have any behaviour issues? ☐ Yes ☐ No If yes, what: _____

Does your child have difficulty sleeping [e.g. nightmares, sleepwalking, insomnia]? ☐ Yes ☐ No

If yes, please specify: _____

Does your child attend daycare? ☐ Yes ☐ No If yes, from what age: _____

Average time spent at computer/watching television/playing with ipad/smart phone each week: _____hours

Is your child nervous or has anyone suggested that your child was nervous? ☐ Yes ☐ No

Do you feel that your child's social and emotional development is normal for their age? ☐ Yes ☐ No

Rate your child's level of stress [stress may be brought on by factors such as moving house/school, divorce, losing a family member]:

LOW 1 2 3 4 5 6 7 8 9 10 HIGH

Chemical Stressors

During the pregnancy, did the mother:

Smoke? ☐ No ☐ Yes Drink alcohol? ☐ No ☐ Yes

Take vitamins/supplements? ☐ No ☐ Yes If yes, what? _____

Take recreational drugs? ☐ Yes ☐ No If yes, what? _____

Become ill? (e.g. flu, gastro, pre-eclampsia) ☐ No ☐ Yes If yes, in what way? _____

Take medication? (e.g. panadol, antibiotics, prescription medications) ☐ Yes ☐ No _____

Receive ultrasounds? ☐ No ☐ Yes. If yes, how many?

Undergo investigations? [eg.amniocentesis, CVS]? ☐ Yes ☐ No

Was the child breast-fed? ☐ Yes ☐ No

If yes, for how long? _____Weeks _____Months _____Years

At what age was:

Formula introduced? _____ Brand: _____ ☐ Breast-fed only

Solid food introduced? _____ Cow's milk introduced? _____

Does the child have any food allergies? ☐ Yes ☐ No If yes, to what? _____

What does your child like to eat/ what is your child's favourite food? _____

What does your child regularly drink? _____

How often does your child receive; processed foods, white sugar, gluten (wheat)& dairy in their diet? ☐ On special occasions ☐ On weekends ☐ A few times per week ☐ Daily ☐ Almost every meal ☐ Never

Are you aware of the impact of food/nutrition on your child's behaviour? ☐Yes ☐ No. Comment (if relevant)_____

_____

Rate your child's diet: ☐Poor ☐Good ☐ Excellent

Did you choose to vaccinate your child? ☐ Yes ☐ No

If yes: ☐Full schedule ☐Reduced schedule ☐ Homeopathic vaccines

Did you notice any changes in your child after their vaccinations? ☐Yes ☐ No If yes what? ☐Fever ☐ Inconsolable crying ☐Irritability Lethargy/Fatigue: ☐ Arching ☐ Drowsiness ☐Bowel disturbances ☐Feeding disturbances

☐Other_____

How many courses of antibiotics has your child received in their lifetime? _____
When was the last course taken and why? _____
Any other chemicals [medications] in the last 6 months? _____
Are there pets at home? ☐Yes ☐ No
Are there any smokers at home? ☐Yes ☐ No

Physical Stressors

Were there any traumas to the mother during the pregnancy? (e.g. falls, accidents etc) ☐Yes ☐ No
If yes, please explain:_____
The literature suggests that over 60% of children fall from a height in the first 12 months of life. Has your child had any falls since birth? (e.g. from change table, off couch, out of bed etc) ☐Yes ☐ No If yes, please explain_____
_____
Any traumas resulting in bruises, cuts stitches or fractures? ☐Yes ☐ No If yes, what?_____
Has your child ever been involved in a motor vehicle accident? ☐Yes ☐ No
Does your child play sport/exercise regularly? ☐Yes ☐ No. If yes, number of hours per week: _____
At what age did your child begin sport/exercising regularly? _____
Weight of school backpack? _____ gms/kgs
Do you feel that your child struggles to carry/wear their backpack? ☐Yes ☐ No
How would you rate your child's posture?
POOR 1 2 3 4 5 7 8 9 10 EXCELLENT
Approximate hours spent at play per week?_____ hours
Does your child have difficulty with co-ordination? ☐Yes ☐ No

---

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

Informed Consent

There are many concerns about the safety of procedures we undergo routinely, the environment we live in, and the food we consume but to name a few. We hope to explain some of the risks and common responses to chiropractic care so that any concerns on these matters may be eased. We hope that having a better understanding of the care you will receive at Vitality Chiropractic will enhance your experience.
Most people will experience some level of discomfort in the early stages of care. This is due to the change in the pattern of the nervous system. It is a normal response during the initial phase of care.
There are always risks associated with any therapeutic intervention! Regarding manual spinal adjustment, the risk of permanent injury or death is approximately 1 in 5,600,000. To place this in perspective, the risk of death from gastric bleeding when taking an aspirin or Paracetamol for aches and pains is approximately 3 in 1000. Statistically there is more chance of being hit by lightning than experiencing permanent damage or dying from a manual adjustment.
We must explain these risks to you so that you can make an informed decision about commencing, or continuing your care. If you have any further concerns please ask your chiropractor.
The adjustments and care you receive here at Vitality Chiropractic will be tailored to your specific needs. In all cases we attempt to provide care in as gentle a fashion as possible. Our range of techniques provide for almost any person, age or condition. If at any stage of your care you have concerns, doubts or questions we encourage you to discuss these matters with your practitioner.
I have read the above and give authority to Vitality Chiropractic to commence/continue chiropractic care for either myself or my dependent. (Whichever is applicable)
Signed: .....
Name (please print): .....
Witness: .....