BAY CHIROPRACTIC

CONFIDENTIAL *INFANT (ages 0 – 2)* PATIENT HISTORY FORM

Sex:		First name:		Surname:	
Address:					
Suburb:		State:		Postcode:	
Mother's Name:		MO:		PH:	
Father's Name:		MO:		PH:	
Date of Birth:	/ /	Age:		Private Health Fund Name?	
Best Contact Email address:					
Who recommended you to our Practice?					
Has child seen a chiropractor before?	**Yes / No**	When was last treatment?			
Immunised?	**Yes / No**	Allergies?			
What is the main reason for attending this chiropractic clinic?					
Has your child had treatment for this complaint before?					
Premature?	**Yes / No**	Head Shape at Birth?	**Normal / Asymmetric**	Torticollis at Birth?	**Yes / No**
Problems requiring treatment at birth?					
Type of Delivery?	**Normal / Breech / Forceps / Caesarean / Suction**				
Child Respirated at Birth?		Vitamin K given?	**Yes / No**		
Birth Weight (Kg)?		Birth Length?		Head Circumference?	
Drugs employed during labour?		Anti D given?	**Yes / No**		
Labour?	**Spontaneous / Induced**	Inducement Reason?			
Labour complications?					
Has your child ever been to hospital or had any surgery? Please give details:					
Developmental Delay in Infancy?	**Yes / No**	Blood Group?		Number of siblings?	

Please turn over

Feeding at discharge?	**Breast / Bottle**	Difficulties Feeding?	**Yes / No**	Breastfed?	months
Still giving Formula?	**Yes / No**	Lactose Intolerance?	**Yes / No**		
Introduction to Solids?	months	Colicky?	**Yes / No**		
Appetite?	**GOOD / FAIR**	Sleep Patterns?	**GOOD / FAIR**		
Crying Patterns?	**GOOD / FAIR**	Activity & Energy Levels?	**GOOD / FAIR**		
Past Illness?	**Yes / No**	Present Illness?	**Yes / No**	Is Your Baby Sick?	**Yes / No**

Have you noticed your baby has problems with any of the following:- Please Circle.

Headaches / Fever
Ear Problems / Hearing
Eye Problems
Nose / Sinus / Hayfever / Allergies
Mouth Problems / Throat Infections / Teething
Respiratory Infections / Asthma / Breathing Problems
New or Recurrent Cough
Bones or Joint Pain / Growth & Development
Psychological / Behavioural / Attention / Seizures
Discomfort Nursing on one side / Head held to one side
Skin Conditions
Lumps / Swellings / Bruising
Gastrointestinal / Abdominal Discomfort / Reflux
Vomiting / Diarrhoea / Constipation / Digesting Food
Genital Problems
Urinary Problems / Bedwetting
Heart Problems
Muscle Control / Lack of Muscle Tone / Balance & Co-ordination

Is your child taking any medication? Please list:

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Has your child taken any long-term medication in the past? Please list:

....

Family History?:

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PARENT / GUARDIAN INFORMATION PRIOR TO TREATMENT

Changes to the law now require all practitioners who manipulate the spine to warn patients of the material risks. In extremely rare circumstances, it is possible to exacerbate a condition. All techniques employed are gentle and safe, and manipulations on children are provided with extreme care.

Chiropractic adjustments (manipulation) of the spine are internationally recognised as being far safer in dealing with neck and low back pain than medication and many other alternatives (A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993).

If you have any questions relating to the treatment your child is about to receive, please speak to the chiropractor. If you understand the above information and give your consent to treatment please sign below.

Parent / Guardian Signature: ..... **Date:** / /