CONFIDENTIAL PATIENT DETAILS- CHILD (BIRTH-10)

Full Name: ______________________ DOB: ____________ Age: ________ M☐ F☐
Address: ______________________ Postcode: ____________
Contact Number: ______________________ Alternate Contact: ______________________
Mother or Father Name: ______________________ Siblings and Ages: ______________________
Has any of the family ever seen a Chiropractor? Yes☐ No☐ Do you still see a Chiropractor? Yes☐ No☐

Have you noticed anything out of the ordinary with your child? ______________________

Pregnancy – Please tick all that apply to the mother:

- ☐ Complications
- ☐ Medications
- ☐ Recreational Drugs
- ☐ Smoked During Pregnancy
- ☐ Alcohol
- ☐ Excessive Cravings
- ☐ Vitamins/Minerals
- ☐ Any Diagnosed Illness
- ☐ Hospitalisation
- ☐ Bleeding
- ☐ Back Pain
- ☐ Excessive Immune Deficiency

Details:
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____

Labour, Delivery and Birth – Please Tick:

- ☐ Greater than 12 hours
- ☐ Fetal Monitoring
- ☐ Forceps
- ☐ Crying Constantly
- ☐ Colouring Problems
- ☐ Caesarean Delivery
- ☐ Hospital Birth
- ☐ Birthing Centre
- ☐ Home Birth
- ☐ Choking
- ☐ Cord around neck
- ☐ Complications
- ☐ Medications
- ☐ Breathing Problems
- ☐ Feeding Problems
- ☐ Premature Birth
- ☐ Jaundice
- ☐ Other……………..

Details:
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Birth Weight: ____________ Birth Length: ____________ Head Circ: ____________

Nutrition:

Is or was the infant: ☐ Formula Fed or ☐ Breast Fed
If Breast-fed, for how long? ____________ When were solids first introduced? ____________
How much dairy food does the infant consume each day? Please list:
____
____
Has the child ever been immunised? If so, were any reactions observed?
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General Health – Please **TICK** conditions that the child has had in the **PAST (P)** or has **CURRENTLY (C)**

P	C	Condition	P	C	Condition
☐	☐	Poor Co-ordination	☐	☐	Headaches
☐	☐	Lack of Concentration	☐	☐	Leg / Arm / or Back Pain
☐	☐	Speech Problems	☐	☐	Problems with Ears or Eyes
☐	☐	Continual Colds, Cough, Throat Infections	☐	☐	Breathing / Asthma
☐	☐	Fidgets constantly / sleeping problems	☐	☐	Stomach or bowel complaints
☐	☐	Been unconscious / had convulsions / fits	☐	☐	Skin, hair, nail or tooth complaints
☐	☐	Limping or unusual walk	☐	☐	Allergies
☐	☐	Other ____________			

Details: ______________________
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Development: When did the infant walk? ____________ Did they go through a good crawling phase? ________

Previous Management: What management, if anything have you tried previously? And what were the results?
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***Signed Parent / Legal Guardian** ______________________ **Date:** ____________

***I have also read and signed the General Palm Beach Chiropractic Consent Form (if care is initiated for this infant)**