CONFIDENTIAL PATIENT INFORMATION
INFANT / CHILD (0-16 YEARS)

HADFIELD
CHIROPRACTIC

Dear Parent,

It is our pleasure to welcome you to Hadfield Chiropractic. Please carefully complete the following questionnaire. Your answers will help us to determine how chiropractic may benefit your child.

CHILD'S NAME ....

DATE OF BIRTH .... AGE .... M ☐ F ☐

PARENT / GUARDIAN'S NAME ....

RELATIONSHIP TO CHILD ....

SIBLINGS NAMES / AGES ....

ADDRESS ....

PHONE (H) ....(M) .... EMAIL ....

GP/CLINIC ....

How were you referred to our clinic? SELF ☐ FRIEND/FAMILY ☐ WEBSITE ☐

OTHER ....

PREGNANCY

Did you require any medication through your pregnancy? Y ☐ N ☐

Details ....

Were there any complications through your pregnancy? Y ☐ N ☐

Details ....

BIRTH

How many weeks pregnant were you when you gave birth? ....

Drugs during delivery Y ☐ N ☐

Details ....

Delivered Normally Y ☐ N ☐

Details ....

Breech Y ☐ N ☐ Posterior Y ☐ N ☐ Premature Y ☐ N ☐

At Term Y ☐ N ☐ Caesarian Y ☐ N ☐ Medically Induced Y ☐ N ☐

Suction Y ☐ N ☐ Forceps Y ☐ N ☐

What was your child's birth weight? ....

Do you believe the birth was traumatic for your child? Y ☐ N ☐

Was your child's head mis-shapen at birth? Y ☐ N ☐

Were there any delivery complications? Y ☐ N ☐

If yes, please provide details ....

Was your child breast fed? Y ☐ N ☐ For how long ....

Were there any feeding issues? Y ☐ N ☐

Details ....

CURRENT HEALTH

What is the main reason for your child's visit today? ....

....

When did this problem start? ....

How did this problem start? ....

What makes this problem better? ....

What makes this problem worse? ....

Have you consulted any other health practitioners for this problem or had prior treatment?

....

Has your child been diagnosed with any of the following conditions?

Allergies ☐ Asthma ☐ ASD ☐ ADHD ☐ Cancer ☐ Epilepsy ☐

Developmental Delay ☐ Heart Condition ☐ Hip Disorders ☐ Scoliosis ☐

Digestive Disorders ☐ Visual Disorders ☐ Hearing Disorders ☐

Other ....

Does your child experience/have a history of experiencing any of the following symptoms?

Neck pain ☐ Back pain ☐ Headache ☐ Arm/Leg pain ☐ Constipation ☐ Diarrhoea ☐

Bedwetting ☐ Earache/infections ☐ Recurrent throat infections ☐ Recurrent chest infections ☐

Growing pains ☐ Sinus pain/infections ☐ Fatigue ☐ Seizures ☐ Night Terrors ☐

Colic ☐ Reflux ☐ Sleeping trouble ☐

Other ....

GENERAL MEDICAL HISTORY

What age did your child begin crawling?.............................. What age did your child begin walking?..............................

Do you consider your child accident prone? Y ☐ N ☐

Has your child has any significant falls? Y ☐ N ☐

Please describe any significant falls or accidents your child has had:

....

....

Has your child ever been involved in a motor vehicle accident? Y ☐ N ☐

Has your child ever been hospitalised or had surgery? Y ☐ N ☐

Details ....

....

Has your child ever had any broken bones or sprain injuries? Y ☐ N ☐

Details ....

....

Has your child required any prescription medication? Y ☐ N ☐

If yes, for what condition? ....

PREVIOUS CHIROPRACTIC CARE

Has your child had previous chiropractic care? Y ☐ N ☐

Reason for care..

Date of last care .... Were x-rays taken? Y ☐ N ☐

Name of Chiropractor/Clinic ....

How would you describe the care received? Excellent ☐ Good ☐ Fair ☐ Poor ☐

INFORMED CONSENT

I have filled in this form to the best of my knowledge. I hereby give consent for my child to undergo a chiropractic consultation and examination, and for the disclosure of their personal information to other health professionals involved in their care. I understand that no accounts are rendered at Hadfield Chiropractic, and all treatment fees are due at the time of service.
ACC Patients: I understand that if my claim is declined, I am liable for any outstanding charges.

Signed ....

Relationship to child ....

Print Name ....

Date ....