Ph: 02 6056 2185 www.completecarechiro.com.au

Child and Baby Case History

Child's Name:	Date:
Parents'/Guardians' Names:	
Home Address:	
Home Phone:	Parent's Work Phone:
Parent's Mobile Phone:	
Parent's Email:	
Birth Date: Age:	Who referred you?
Sex:	Previous Chiropractic Care? Yes No
Siblings and ages:	
Emergency Contact Name:	
Phone number:	Relationship to child:
Family Doctor Name:	Clinic Name:
Date and reason of last visit:	

Other Health Care Professionals (Medical Specialist, Naturopath, Physiotherapist, OT, Massage Therapist, etc.)

Name:	Professional Designation:
Clinic Name:	Date:
Reason of last visit:	
Name:	Professional Designation:
Clinic Name:	Date:
Reason of last visit:	

Why have you decided to have your child evaluated by a Chiropractor?

- o He / She is continuing ongoing care from another chiropractor.
- o I recently had my spine checked and understand the value in getting my child checked.
- o I would like my child's nervous system assessed to achieve optimal health & function.
- o I want to improve my child's immune function, balance/coordination, behaviour, sleep.
- o He / She has a specific condition and I've learned that chiropractic may be able to help.
  Please specify: _____
  Is it getting worse, better, staying the same? _____
  What aggravates it? _____ What improves it? _____
- o I have concerns about his/her health and I'm looking for answers.
  Please specify: _____

Wellness Profile

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Many of the common health challenges that adults experience originates during the developmental years, some starting at birth. Layers of damage to the spine and nervous system occur as a result of various traumas, toxins, and emotional stress. The result may be misalignment to the spinal column and damage to the nervous system – a condition called Vertebral Subluxation.

Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's ability to heal. **What signals has your child's body been communicating?**

o Asthma	o Allergies	o Food Sensitivities
o Failure to Thrive / Slow Weight Gain	o Respiratory Tract Infections	o Red, Swollen, Painful Joint
o Asymmetrical Crawling or Gait	o Slow or Absent Reflexes	o Trouble Feeding on One Side
o Reflux	o Colic	o Flatulence
o Digestive Problems	o Frequent Diarrhoea	o Constipation
o Headaches/Migraines	o Neck Pain	o Back Pain
o Torticollis / Head Tilt	o Growing Pains	o Scoliosis
o Sinus Problems	o Strep Throat	o Tonsillitis
o Frequent Colds / Croup	o Ear Infections	o Recurrent Fevers
o Rashes	o Eczema	o Seizures
o Night Terrors	o Sleep Problems	o Weight Challenges
o Bed Wetting	o Tip Toe Walking	o Tremors / Shaking
o ADD / ADHD	o Autism / PPD	o Frequent Crying Spells
o Sensory Processing Issues	o Coordination / Balance Issues	o Consistent Mouth Breathing

Prenatal Profile

Adopted	Prenatal history unknown	Birth history unknown
Complications during pregnancy: No Yes, please specify:		
Ultrasounds during pregnancy: No Yes, please specify:		
Medications during pregnancy: No Yes, please specify:		
Exposure to drugs, alcohol, cigarettes, or second-hand smoke during pregnancy: No Yes, please specify:		

Birth Experience

Location of Birth: Home Hospital Birthing Centre Other:
Birth Attendants: Doula Midwife GP OB Other:
Medications during labour / delivery (including IV antibiotics, Pitocin, Epidural, Pethidine, etc.): No Yes, please specify:
Was your child at any time during your pregnancy in a constrained position? No Yes Unsure If yes, please specify: Breech Transverse Face / Brow presentation
Was your delivery vaginal or C-section? If C-section, was it planned or emergency?
Were any of the following interventions used? Forceps Vacuum Extraction Other
Were there any complications during delivery? No Yes If yes, please specify:

How long was the labour from the first regular contractions to the birth? hours
Was the baby born with any purple markings / bruising on their face or head? No Yes
Any concerns about misshapen head at birth? No Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth?	
Weight:	Length:
If known, APGAR scores at: 1 minute: /10	5 minutes: /10
Was the baby ever admitted to the NICU (neonatal intensive care unit)? No Yes	If yes, for how long and why?
Was any medication given to the child at birth? No Yes Unsure	If yes, what medication and why?
Was your child exclusively breastfed? No Yes, how long?	
Was your child breastfed + formula fed? No Yes, how long?	
Did your child show any sensitivities to formula (reflux, eczema, arching back)? No Yes	
What age did you introduce solid foods to your child? months	
Did you introduce cereal or grains within your child's first year? No Yes	
Did your child spend a lot of time in any baby devices (bouncy seats, swings, bumbos, jolly jumpers, car seats, etc.)? No Yes Which ones?	

Physical Traumas

Has your child ever fallen from any high places? No Yes
Has your child ever been involved in a motor vehicle accident? No Yes
Has your child been seen on an emergency basis? No Yes
Has your child broken any bones? No Yes
Has your child had any previous hospitalisations? No Yes
Has your child had any previous surgeries? No Yes

Lifestyle & Health

Does your child use a tablet, computer, or video game? Never Rarely Daily hrs/day:
Does your child watch TV? Never Rarely Daily Several hrs/day
Does your child exercise? No Daily Weekly Seasonally
Does your child play contact sports? No Daily Weekly Seasonally
Does your child sleep on their…? Back Belly Sides (both, right, left)
Does your child carry a back pack? No Yes
Do they wear their back pack on 2 shoulders? No Yes
Do they wear their back pack with hip support? No Yes
Does your child show excessive or uneven shoe wearing out? No Yes
Does your child wear custom orthotics? No Yes, For what purpose?
Has your child been exposed to antibiotics? No Yes If yes, how many doses in past 6 months? Reason:
Has your child been exposed to medications? No Yes If yes, which ones? If yes, how many doses in past 6 months? Reason:
How many glasses of water/day does your child have? 0 1-3 4-6 7-9 10+
How many glasses of cow's milk, juice, and soda/day? 0 1-3 4-6 7-9 10+
Any food/drink allergies or sensitivities? No Yes, please specify:
Does your child take any supplements/vitamins? No Yes, please specify:

Goals & Consent

Do you feel your child is developmentally appropriate for their age?
Intellectually: Yes No Emotionally: Yes No Physically: Yes No
What is your primary goal for your child at our clinic?

Our goals are to provide a detailed assessment of your child's current health status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations.
You've taken an important step for your child's future through a chiropractic evaluation.

May we communicate with your family doctor regarding your child's care if necessary? Yes No

Consent to Evaluation of a Minor Child

I, _____, being the parent or legal guardian of _____,
(print name of consenting adult) (print name of minor)
hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, and physical examination. Any findings will be communicated before consenting to commencement of treatment, if appropriate.

Consenting Adult's Signature _____ Date _____