



Chiropractic – child health questionnaire | 0-5 years

The information on this form is and will remain strictly confidential

Please read the following sections carefully and write your answer / tick where appropriate.

PATIENT DETAILS

Child's Name: _____ M / F Date of Birth: ____ / ____ / ____ Age: _____

Parent / Guardian's Name: _____

Address: _____

City: _____ State: _____ Postcode: _____

Telephone (Home): _____ (Mobile): _____ (Work): _____

Email: _____

Name of Paediatrician / Doctor: _____

Telephone: _____

Is your family a member of a Private Health Fund that covers Chiropractic Care? ☐ YES ☐ NO

Name of your Fund: _____

Who referred you to this Chiropractic Office?: _____

Current concern with your child: _____

PRE-NATAL HISTORY (CONCEPTION to BIRTH)

While pregnant, did the mother:

Smoke / or Drink Alcohol during Pregnancy? ☐ YES ☐ NO List: _____

Take any Medications during Pregnancy? ☐ YES ☐ NO List: _____

Have Illness / Complications during Pregnancy? ☐ YES ☐ NO List: _____

Have any falls / traumas during Pregnancy? ☐ YES ☐ NO List: _____

Have Ultrasounds During Pregnancy? ☐ YES ☐ NO Number: _____

Duration of Pregnancy in weeks: _____ Age of Mother at time of Birth: _____

PERI-NATAL HISTORY (BIRTH)

Place of Birth: ☐ Hospital ☐ Birthing Centre ☐ Home

Provider: ☐ Midwife ☐ Medical Doctor ☐ Other

Child's Birth Weight: _____ APGAR Scores: @1min _____ @5min _____ ☐ Unsure

Type of Birth:

☐ Natural

☐ Emergency Caesarean Section

☐ Planned Caesarean Section

If not Caesarean Section was other birth intervention required?:

☐ Forceps Extraction

☐ Vacuum Extraction

Use of Drugs during birth?: ☐ YES ☐ NO Was the labour chemically induced?: ☐ YES ☐ NO

Complications during Delivery?: ☐ YES ☐ NO List: _____

Genetic Disorders or Disabilities: ☐ YES ☐ NO List: _____

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NEO-NATAL HISTORY

Immediately after Birth/During Infancy, did any of the following occur?

Need for child to be re-separated? ☐ YES ☐ NO

Need for child to be in a humidicrib? ☐ YES ☐ NO

Administered medications? ☐ YES ☐ NO List: _____

Recent illness? ☐ YES ☐ NO

Surgery? ☐ YES ☐ NO

Difficulty Feeding / Latching / Sucking? ☐ YES ☐ NO

Breast Fed: ☐ YES ☐ NO How Long: _____

Formula Fed: ☐ YES ☐ NO How Long: _____

Type: _____

Introduced to Solids at: _____ months, and Cows' milk at _____ months

Failure to grow/gain weight? ☐ YES ☐ NO

Disrupted sleep patterns? ☐ YES ☐ NO

Hours of sleep per night: _____ Number of naps in day: _____ Length of naps in day: _____

Speech or Language difficulties? ☐ YES ☐ NO

OTHER DEVELOPMENTAL HISTORY

Was your child delayed at any of the following?

Respond to Sound ☐ YES ☐ NO

Respond to Visual Stimuli ☐ YES ☐ NO

Hold Head Up ☐ YES ☐ NO

Sit Up ☐ YES ☐ NO

Crawling ☐ YES ☐ NO

Stand Alone ☐ YES ☐ NO

Walk Alone ☐ YES ☐ NO

Has your child fallen from a height? (eg bed, changing table, down stairs)? ☐ YES ☐ NO

List: _____

Recent illness? ☐ YES ☐ NO

Other Falls onto head? ☐ YES ☐ NO

List: _____

Has Your Child Ever Been Involved in a Car Accident? ☐ YES ☐ NO

List: _____

Has your child ever had any broken bones or sprain injuries? ☐ YES ☐ NO

List: _____

Has your child been involved in high impact or contact type sports (eg, Soccer, Football, Gymnastics, Cricket, Martial Arts)? ☐ YES ☐ NO

List: _____

Has Your Child Been Seen on an Emergency Basis or hospitalised? ☐ YES ☐ NO

List: _____

Is your child currently taking medication of any kind? ☐ YES ☐ NO

List: _____

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



MEDICAL HISTORY:

Has your child experienced any of the following:

- | | | | |
|---|---|--|---|
| <input type="radio"/> ADHD/ADD | <input type="radio"/> Allergies | <input type="radio"/> Anxiety/Depression | <input type="radio"/> Autism/Asperger's |
| <input type="radio"/> Asthma/Bronchitis | <input type="radio"/> Breathing problems | <input type="radio"/> Back / Neck Pain | <input type="radio"/> Bed Wetting |
| <input type="radio"/> Blood Noses | <input type="radio"/> Constipation | <input type="radio"/> Colic | <input type="radio"/> Convulsions/seizures/epilepsy |
| <input type="radio"/> Coughs/Colds | <input type="radio"/> Developmental Delay | <input type="radio"/> Diarrhoea | <input type="radio"/> Difficult Urination |
| <input type="radio"/> Difficulty Swallowing | <input type="radio"/> Digestive Troubles | <input type="radio"/> Ear Ache/Infections | <input type="radio"/> Ear Infections – 2+ |
| <input type="radio"/> Fatigue | <input type="radio"/> Failure to Thrive | <input type="radio"/> Flaking Scalp | <input type="radio"/> Gas |
| <input type="radio"/> Hyperactivity | <input type="radio"/> Headache | <input type="radio"/> Hearing Loss | <input type="radio"/> Poor/Excess Weight Gain |
| <input type="radio"/> Irritability | <input type="radio"/> Meningitis | <input type="radio"/> Stomach Pains | <input type="radio"/> Milk/Lactose Intolerance |
| <input type="radio"/> Night Pain | <input type="radio"/> Rashes | <input type="radio"/> Vision Loss | <input type="radio"/> Muscle Tone Problems |
| <input type="radio"/> Reflux | <input type="radio"/> Sinus/Allergies | <input type="radio"/> Skin Rashes | <input type="radio"/> Sleep Issues |
| <input type="radio"/> Toe Walking | <input type="radio"/> Unusual Movements | <input type="radio"/> Fall - crib/change table | |
| <input type="radio"/> Fall from play equipment/bike/tree etc. | | | |

For Girls, onset of Menarche (first period): ☐ YES ☐ NO Age: _____

CHILDHOOD DISEASES

- ☐ Chicken Pox @ Age: _____
 ☐ Mumps @ Age: _____
 ☐ Rubella @ Age: _____
☐ Whooping Cough @ Age: _____
 ☐ Measles @ Age: _____
☐ Other (List: _____) @ Age: _____

CHIROPRACTIC HISTORY

Has your child had previous Chiropractic care? ☐ YES ☐ NO
 If Yes, what is the name of your previous Chiropractor? : _____
 Where are / were they located? : _____
 When was the last visit / treatment? : _____
 Were X-Rays taken? ☐ YES ☐ NO
 If Yes, when?: ____ / ____ / ____

Was the previous Chiropractor a Gonstead practitioner? ☐ YES ☐ NO ☐ NOT SURE
 What were the results of your previous treatment?
☐ Excellent ☐ Satisfactory ☐ Fair ☐ Did Not Help ☐ Got Worse

Parental/Guardian Consent for Examination and Treatment of a Minor

I authorise for my child to be appropriately examined and treated for their condition. I understand that there are minor risks associated with Chiropractic Manipulation and that these risks are minimised by a thorough examination and the utilisation of the Gonstead System of Chiropractic. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and agree to pay the fees which have been explained to me at the time this service is rendered.

Child / Patient Name (Printed)

Patient / Guardian Signature

Date: ____ / ____ / ____

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