fairlight chiropractic
well-being for all

CHILDREN'S HEALTH QUESTIONNAIRE

Surname: ____________________ Child's Names:__________________ Parent's Name:_____________

Address : ____ Post Code:__________

Phone: Work ______________________ (hours _____ to _____)   Home: ______________________

Sex: Male / Female   Date of Birth: ____ / ____ / 20 ___   Age: ________

What health fund do you belong to ________________ Does it cover Chiropractic?   Yes / No

Has your child had Chiropractic care before ?   Yes / No

If yes, for what condition ? ____

Were X-Rays taken ? Yes / No   Has your child ever suffered any injury or serious illness? Yes / No

If yes, please specify: ____

PLEASE WRITE IN YOUR OWN WORDS YOUR CHILD'S MAIN COMPLAINT.

____

REGARDING LABOR:

Was it Chemically Induced?   Yes / No

Doctor Assisted?   Yes / No

Was C - Section Performed?   Yes / No

Were Forceps/Suction Extraction Used?   Yes / No

Did Doctor Have Hands on the Infant?   Yes / No (most infants are born with hands or forceps)

Were You Lying Down?   Yes / No

Was Family Member Present   Yes / No

If yes, who? ____

Was your child premature?   Yes / No   If so, what was his / her weight? ______________

TICK OFF ANY OF THE FOLLOWING SYMPTOMS YOUR CHILD HAS EXPERIENCED IN THE PAST 6 MONTHS.

__ LOW BACK PAIN   __ NECK PAIN   __ DIGESTIVE TROUBLES

__ ASTHMA   __ HEADACHES   __ ALLERGIES

__ SLEEPING DISORDERS   __ COLD / FLU   __ EAR/THROAT INFECTIONS

__ BREATHING PROBLEMS   __ FATIGUE   __ IRRITABILITY

__ HYPERACTIVITY	__ BLOODY NOSES	__ MENINGITIS
__ DIARRHEA	__ CONSTIPATION	__ BED WETTING
__ RASHES	__ COLIC	__ MILK or LACTOSE INTOLERANCE

OTHERS: ____

REGARDING YOUR CHILD TODAY:

Is your child accident prone?	Yes / No
Has the child had any falls down steps?	Yes / No
Has your child ever fallen from heights over 2 feet?	Yes / No
Has your child ever been involved in a motor vehicle accident?	Yes / No
Has your child ever been hospitalized or had surgery?	Yes / No
Has your child ever had any broken bones or sprain injuries?	Yes / No
Is your child on medication?	Yes / No
Has your child had a scoliosis examination by an approved scoliosis determination procedures clinic?	Yes / No
Has your child a learning disorder?	Yes / No
Has your child a poor posture?	Yes / No
Is your child nervous, or has anyone suggested that your child was nervous?	Yes / No
Does your child show any signs of nervousness, twitching or excessive talking to themselves?	Yes / No

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

____

____

Safety/Risk Profile:

Due to it's wonderful results Chiropractic is the largest drug-free health care profession in the world. It is also recognised as being a safe and effective. This is particularly true in relation to children's care. With any form of health care there are some risks involved and you need to be aware of this. Current regulations require health care practitioners to disclose any potential for material injury associated with care provided. In rare instances the risks associated with the proposed care may include, although are not limited to, muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries, strokes (or like episodes) and an exacerbation and/or aggravation of underlying conditions.

Please discuss any concerns you may have with your Chiropractor before your Child begins care.

Signature of guardian / Parent

____ Date ______________