Helena Valley Chiropractic

08 9255 1052

Child Chiropractic Welcome Form

PLEASE PRINT CLEARLY

CHILD'S 1ST NAME:____ DOB:___/__/____ AGE:_____

CHILD'S SURNAME:___________________ FATHER'S FULL NAME:___________________________

MOTHER'S FULL NAME:____

ADDRESS:____

HOME PH NO:_____________________ MOBILE CONTACT NO:___________________________

PEDIATRICIAN/GP NAME AND ADDRESS:____

____

BIRTH WEIGHT:_______________ CURRENT WEIGHT:_____________ CURRENT HEIGHT:________

NAME AND AGES OF SIBLINGS:____

____

HOW DID YOU HEAR ABOUT OUR CLINIC?____

PRIVATE HEALTH FUND NAME:___________________________ NUMBER:_____________________

PATIENT HEALTH INFORMATION:

MAIN COMPLAINT(S)____

IS THE PROBLEM (CIRCLE): PROGRESSIVELY GETTING WORSE/STAYING THE SAME/GETTING BETTER/

CONSTANT/FREQUENT/OCCASIONAL?

HAS YOUR CHILD BEEN TREATED FOR THIS CONDITION? YES / NO

IF SO WHEN?____

Obstetrical procedures can cause tractioning and twisting of an infant's spine, producing **Vertebral** Subluxation (a spinal bone which has lost its normal position and range of motion causing irritation to delicate nerve tissue).

TYPE OF BIRTH (circle all that apply) VAGINAL / FORCEPS / BREECH / C-SECTION / HOME / HOSPITAL

BIRTHING CENTRE / OTHER: ____

WHAT WAS THE GESTATION PERIOD FOR YOUR CHILD? _____________________________________

HOW LONG WAS THE ENTIRE LABOUR? ____

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PROBLEMS / COMPLICATIONS DURING PREGNANCY / DURING LABOUR / DELIVERY? _____________

____

INFANT FEEDING (CIRCLE): BREAST / BOTTLE / FORMULA – IF FORMULA, WHAT TYPE? ____________

QUALITY OF SLEEP: GOOD / FAIR / POOR – HOURS PER DAY: _________ HOURS PER NIGHT: _______

IMMUNIZATIONS: YES / NO – SPECIFY: ____

SURGERY AND / OR MEDICATIONS: ____

MOST RECENT FALL: ____

OTHER SIGNIFICANT FALLS / TRAUMA / MOTOR VEHICLE ACCIDENT(S): ________________________

SPORTS AND RECREATIONAL ACTIVITIES: ____

Vertebral subluxation *can cause irritation to different nerves that can affect any organ or tissue, causing conditions now or in the future.*

Has your child ever suffered from:

ADHD Allergy Asthma Bed Wetting Broken Bones

Back Pain Colic Headache Neck Pain Digestive Problems

Tonsillitis Scoliosis Sleeping Problems Growing Pains

Otis Media (ear infection) Other ____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this clinic and its Doctor(s) to oversee care as the so deem necessary to my son / daughter / ward (upon approval of parent or guardian)

RELATIONSHIP: ___________________________ SIGNATURE: ______________________________

PLEASE NOTE:

PAYMENT: Payment on the day by Cash or Eftpos only. This Clinic DOES NOT RUN ACCOUNTS.

MISSED APPOINTMENTS: A missed appointment fee applies if less than 8 hours notice is given. We have a telephone answering service for your convenience.

I, _______________________________ have read and fully understand the above statements and accept chiropractic care for my child on this basis.

SIGNATURE: ______________________________ DATE: ___ /___/______