

CONFIDENTIAL PATIENT DETAILS

Full Name: _____ DOB: _____ Age: _____ M F
Address: _____ Postcode _____
Contact Number: _____ Alternate Contact: _____
Mother or Father Name: _____ Siblings and Ages: _____
Has any of the family ever seen a Chiropractor? Yes No Do you still see a Chiropractor? Yes No

Have you noticed anything out of the ordinary with your child? _____

Pregnancy – Please tick all that apply to the mother

- | | | |
|--|--|--|
| <input type="checkbox"/> Complications | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Hospitalisation |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Excessive Cravings | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Recreational Drugs | <input type="checkbox"/> Vitamins/Minerals | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Smoked During Pregnancy | <input type="checkbox"/> Any Diagnosed Illness | <input type="checkbox"/> Excessive Immune Deficiency |

Details: _____

Labour, Delivery and Birth – Please Tick

- | | | |
|--|---|---|
| <input type="checkbox"/> Greater than 12 hours | <input type="checkbox"/> Hospital Birth | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Fetal Monitoring | <input type="checkbox"/> Birthing Centre | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Forceps | <input type="checkbox"/> Home Birth | <input type="checkbox"/> Feeding Problems |
| <input type="checkbox"/> Crying Constantly | <input type="checkbox"/> Choking | <input type="checkbox"/> Premature Birth |
| <input type="checkbox"/> Colouring Problems | <input type="checkbox"/> Cord around neck | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Caesarian Delivery | <input type="checkbox"/> Complications | <input type="checkbox"/> Other |

Details: _____

Birth Weight: _____ Birth Length: _____ Head Circ: _____

Nutrition:

Is or was the infant Formula Fed or Breast Feeding

If Breast fed, for how long? _____ When were solids first introduced? _____

How much dairy food does the infant consume each day? Please list _____

Has the child ever been immunized? If so were there any reactions observed? _____

General Health – Please **TICK** any conditions that the child has had in the **PAST (P)** or has **CURRENTLY (C)**.

- | | | | |
|---|--------------------------|--------------------------------------|--------------------------|
| P | C | P | C |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Poor Co-ordination | | Headaches | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of Concentration | | Leg / Arm / or Back Pain | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Speech Problems | | Problems with Ears or Eyes | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Continual Colds, Cough, Throat Infections | | Breathing / Asthma | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fidgets constantly / sleeping problems | | Stomach or bowel complaints | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Been unconscious / had convulsions / fits | | Skin, hair, nail or tooth complaints | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Limping or unusual walk | | Allergies | |
| <input type="checkbox"/> | <input type="checkbox"/> | | |
| Other _____ | | | |

Details: _____

Development:

When did the infant walk? _____

Did they go through a good crawling phase? _____

Previous Management:

What management, if anything have you tried previously? And what were the results? _____

***Signed Parent / Legal Guardian** _____ **Date:** _____

*I have also read and signed the General Absolute Health Consent Form (if care is initiated for this infant)