



MONA VALE CHIROPRACTIC AND NATURAL THERAPIES
 Suite 50, Level 2, 90 Mona Vale Road, Mona Vale NSW 2103
 Phone: (02) 9979 7700 Fax: (02) 9979 7300

DATE _____

Child's Details

FULL NAME _____
 ADDRESS _____ POSTCODE _____
 PHONE (H) _____ (W) _____ (M) _____
 EMAIL _____
 DATE OF BIRTH _____ (Age) MALE / FEMALE
 EXERCISE ACTIVITIES AND HOBBIES _____

 HEIGHT _____ cms WEIGHT _____ kg
 Have your child seen a chiropractor before? YES /NO (If yes, When? _____)
 Was that for a checkup for a specific issue? _____

Family Details

Names of Parents/Guardians _____
 Names and ages of Siblings _____

How did you hear about us? (Please name where specified)

- HEALTH PRACTITIONER _____
- FRIEND/FAMILY _____
- GOOGLE/SEARCH ENGINE _____
- WEBSITE _____
- YELLOW PAGES _____
- FACEBOOK _____
- OTHER _____

BEGINNING YEARS OF LIFE	SYMPTOMS CURRENTLY EXPERIENCING	
<p>Research is showing that many of the health challenges that occur later in life originate during the developmental years of our lives. That's why many parents bring their children in for regular spinal check-ups so they can be as healthy as possible and avoid future problems.</p> <p><u>PRENATAL HISTORY</u> Number of ultrasounds during pregnancy _____ Number of weeks pregnant you were at delivery _____</p> <p><u>LABOUR/DELIVERY</u> How was your child delivered? <input type="checkbox"/> Hospital with Doctor <input type="checkbox"/> Hospital Midwife <input type="checkbox"/> Home with midwife <input type="checkbox"/> Normal Vaginal Delivery <input type="checkbox"/> Caesarean <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum extraction/Suction <input type="checkbox"/> Chemically induced <input type="checkbox"/> Breech presentation <input type="checkbox"/> Posterior presentation <input type="checkbox"/> Epidural/Pethidine injection</p> <p>How many hours were you in labour? _____ Were there any delivery complications? <input type="checkbox"/> Yes <input type="checkbox"/> No Details _____</p> <p>Any evidence of birth trauma? <input type="checkbox"/> Bruising/Abrasions <input type="checkbox"/> Misshaped head <input type="checkbox"/> Stuck in Canal <input type="checkbox"/> Cord around neck APGAR Scores at birth: _____ Birth Weight _____</p> <p><u>NUTRITION</u> <input type="checkbox"/> Breast fed How long? _____ <input type="checkbox"/> Formula Fed How long? _____ <input type="checkbox"/> History of Colic <input type="checkbox"/> History of reflux How many times has your child taken antibiotics? _____</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Headaches <input type="checkbox"/> Back pain/Neck Pain <input type="checkbox"/> Hip problems <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Recurrent chest pain <input type="checkbox"/> Growing Pain <input type="checkbox"/> Visual disorders <input type="checkbox"/> Poor-coordination <input type="checkbox"/> Learning difficulties <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Psoriasis, Eczema or Skin Condition <input type="checkbox"/> Constipation/Diarrhoea <input type="checkbox"/> Digestive Disorders <input type="checkbox"/> Bedwetting <input type="checkbox"/> Poor sleeping habits <input type="checkbox"/> Allergies <input type="checkbox"/> Fever <input type="checkbox"/> Asthma <input type="checkbox"/> Seizures <input type="checkbox"/> Chronic Colds <input type="checkbox"/> Earaches/Infections <input type="checkbox"/> Recurrent Tonsillitis <input type="checkbox"/> Travel Sickness <input type="checkbox"/> Other _____ 	
	PAST/PRESENT ILLNESSES	FAMILY HISTORY
	<ul style="list-style-type: none"> <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Depression/Anxiety <input type="checkbox"/> Asthma/Bronchitis <input type="checkbox"/> Diabetes Type I/Type II <input type="checkbox"/> Hyper/Hypo Thyroidism <input type="checkbox"/> Rheumatoid Disease <input type="checkbox"/> Scheuermann's Disease <input type="checkbox"/> Spinal Curvature/Scoliosis <input type="checkbox"/> Spinal Fracture <input type="checkbox"/> Spondylolisthesis <input type="checkbox"/> Whiplash <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Other _____ 	<ul style="list-style-type: none"> <input type="checkbox"/> Back problems <input type="checkbox"/> Headaches <input type="checkbox"/> Heart disease <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Diabetes <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other _____

Please list MEDICATIONS AND SUPPLEMENTS	VACCINATED? Any reactions noted?						
OPERATIONS AND ACCIDENTS including major falls, dislocations, sprains or car accidents etc							
WHAT IS YOUR CHILD'S PRIMARY CONCERN TODAY?	SEVERITY OF PAIN (1-10) 1=mild- 10=severe	QUALITY OF PAIN (eg; sharp, dull, burning, ache, constant or intermittent)	DO YOU EXPERIENCE REFERRED PAIN (shooting, pain, pins & needles or numbness)?	WHEN AND HOW DID THE ISSUE BEGIN?	ANY AGGRIVATING OR RELEIVEING FACTORS? What makes it better or worse	HAVE YOU HAD THIS CONDITION BEFORE? When?	HAVE YOU RECEIVED ANY CARE OR TREATMENT FOR THIS ISSUE TO DATE?

What other concerns do you have regarding the health of your child?

Chiropractors Comments

Please mark any areas of discomfort or concern

