

Child's Details

Full Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Address: _____ Suburb: _____ Postcode: _____

Home Phone: _____ Email: _____ Mobile: _____

Family Details

Names of Parent/Guardians: _____

Names and Ages of Siblings: _____

How did you hear about us?

Health Practitioners _____
 Friend/Family _____
 Google _____
 Website _____
 Facebook _____
 Other _____

Current Complaint

What are your main complaints: 1. _____

2. _____

3. _____

How long have you had this problem? _____

Cause of the problem: _____

Onset: Gradual Sudden

Other complaints: 1. _____

2. _____

3. _____

Recent trauma? No Yes details: _____

Progression: Worse Better Same

Frequency: Constant Comes and goes

What makes it worse? 1. _____

2. _____

3. _____

What makes it better? 1. _____

2. _____

3. _____

Have you had a prior diagnosis: _____

Have you had prior treatment: _____

What was the outcome of this treatment: _____

Has your child had chiropractic before: No Yes when: _____

Is your child taking any medication?

Drug/medication Names	Reasons for use

Has your child had any falls or injuries: _____

Has your child had any medical procedures done: _____

Has your child had any illnesses: _____

GENERAL

Vaccinated? No Yes Any reactions noted? _____

How many times has your child taken antibiotics? _____ What issues were you addressing? _____

Has your child had any of the following common presentations to our clinic:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Pins & Needles | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Recurrent ear infections | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Fevers | <input type="checkbox"/> URTI |
| <input type="checkbox"/> Other immunity problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Constipation | <input type="checkbox"/> Concentration issues |
| <input type="checkbox"/> Learning or behavioural problems | <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Mood or emotional issues | <input type="checkbox"/> UTI |
| <input type="checkbox"/> Sleep issues | <input type="checkbox"/> Snoring | <input type="checkbox"/> Nightmares/sleep terrors | <input type="checkbox"/> Sleep apnoea |
| <input type="checkbox"/> Skin rash | <input type="checkbox"/> Developmental delay | | |

Do you have a family history of any serious health problems: No Yes details: _____

Does your child have any other health conditions? No Yes details: _____

Does your child report pain/discomfort anywhere? _____



BIRTH HISTORY

Length of pregnancy: _____ Birth Weight _____

Were you induced? No Yes

Birth Place: Hospital Home Other _____

Vaginal Birth: No Yes Membr Rupture: No Yes

Forceps: No Yes Vacuum: No Yes

Epidural: No Yes Traction: No Yes

Labour Medication: No Yes

Length of Labour: Contractions: _____
Pushing: _____
Placenta: _____

C-Section: No Yes Planned Emergency

Presentation: Anterior Posterior Transverse Breech

Resuscitation needed: No Yes

APGAR: _____

NEWBORN PERIOD

Was your baby breast fed: No Yes Did they feed well: No Yes

Did they have a good suck and latch: No Yes Did your baby fuss when feeding: No Yes

Was he settled after the feed: No Yes Did your baby have reflux: No Yes

GENERAL HEALTH

Does your child have any food allergies or intolerances: No Yes, details: _____

DEVELOPMENTAL MILESTONES

At what age did your child reach the following milestones?

Reaching for objects: _____ Propping himself up on his tummy: _____

Playing with his own two hands: _____ Started to roll over: _____

Will sit up when pulled by hands: _____ Rolling fully: _____

Sit alone and go into crawl position: _____ Sitting on own and crawling: _____

Standing on furniture: _____ Walk along furniture: _____

Lower from standing: _____ Starting to walk: _____

Drink from a cup: _____

Any other comments you would like to make?

Dr Comments:

PATIENT INFORMATION

ABOUT PAEDIATRIC CHIROPRACTIC

At Mona Vale Chiropractic we are committed to the safest and most effective methods of restoring normal function to your child. You will notice that chiropractic for young children is different than for adults. Babies in particular need very little pressure to make necessary changes and achieve the desired result. Young children also do not have years of damage to their spines and therefore can respond more rapidly than adults.

Chiropractic care for children has a remarkable safety record.

Currently there are in excess of 30 million child visits to chiropractors each year. Yet studies in paediatric chiropractic have failed to find any consistent evidence of serious adverse reactions. In rare occasions mild irritability has been recorded.

In 2014 a massive review of studies across the world on the safety of manual therapy for children was undertaken. Spanning many hundreds of millions of child visits to all manual therapists (chiropractors, osteopaths, physiotherapists and medical physicians) – of all these visits, only 15 serious adverse reactions were found.

Furthermore, underlying pre-existing pathology was associated in the majority of these cases.

Compare this to the current DAILY rate of 1600 adverse drug events in children attending outpatient clinics in the USA (yes per day), or in the year 2000, there were 4483 deaths of hospitalised children due to patient safety events -that's 86 deaths per week.

We can honestly say chiropractic care for children is one of the safest healthcare interventions they can have.

DECLARATION:

I have read the above information and have noted any question I wish to discuss with my Chiropractor. I hereby give consent for my child to receive Chiropractic by any of the Chiropractors at [Mona Vale Chiropractic](#) and I acknowledge that I can ask questions at any time and revoke my consent to care at any time.

Patient's Name: _____

Parent's/Guardian's Name: _____

Parent's/Guardian's Signature: _____

Chiropractor's Signature: _____

Date: _____

A.Todd, M.Carroll,A.Robinson E.Mitchell Adverse events due to Chiropractic and Other Manual Therapies for Infants and Children: A review of the Literature JMPT 2014 (Oct30)

Miller, J., Benefield, K. (2008)Adverse effects of spinal manipulative therapy in children younger than 3 years: A retrospective study in a chiropractic teaching clinic JMPT 2008.06.002

Bourgeois, et al.Pediatric Adverse Drug Events in the Outpatient Setting: An 11-Year National Analysis Pediatrics October 2009; 124:4 e744-e750