



CLIENT INFORMATION

Name _____
Address _____
Suburb _____ Post Code _____
Home Phone _____
Mobile Phone _____
Email _____
Sex M F Age _____ Birthdate _____

Mother's Name _____
Mother's Occupation _____
Mother's Phone _____
Mother's Email _____

Father's Name _____
Father's Occupation _____
Father's Phone _____
Father's Email _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____

Who may we thank for referring you?

HOW CAN WE HELP YOUR CHILD?

Wellness Checkup Other: _____

If your child is already experiencing a symptom, please describe it:

Has your child been treated on an emergency basis? Yes No

Please describe: _____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

Back/Other Pain Gestational Diabetes Pre/Eclampsia Strep B Nausea/Vomitting
 Pre-Term Fatigue Swelling Other (please describe) _____

BIRTH HISTORY

Type of birth (check all that apply):

Hospital Birth Center Home Normal / Vaginal Breech
 Cesarean Scheduled/Induced Epidural

Problems during labor / delivery? _____

Antibiotics Congenital Anomalies Failure to Thrive Jaundice Meconium
 Respiratory Distress Extended Hospitalization Other _____

GROWTH & DEVELOPMENT

Infant feeding: Breast Bottle Formula

Number of hours of sleep each night: _____ Quality of sleep: _____

At what age did the child: _____

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk unsupported: _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

- Chicken Pox Measles Rubeola
 Mumps Rubella Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

- Allergies Broken Bones Digestive Issues
(constipation/diarrhea) Hypertension Orthopedic Problems
 Anemia Chronic Ear Aches Juvenile
Rheumatoid Arthritis Paralysis
 Arm Problems Colds/Flu Dizziness Poor Appetite
 Asthma Colic Fainting Joint Problems Ruptures/Hernias
 Back Aches Convulsions/Seizures Headaches Leg Problems Sinus Trouble
 Bed Wetting Delayed Speech Heart Trouble Neck Problems Tuberculosis
 Behavioral Problems Diabetes Hyperactivity Neuritis Walking Problems

Have you vaccinated your child?

- No Yes As scheduled Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

MEDICATIONS (list)

SURGERIES (list)

FAMILY HISTORY (list)

SIBLINGS

How many children do you have? _____

Number of pregnancies: _____

Children's' Ages: _____

Are you currently pregnant? No Yes, I'm due: _____

Childrens' health concerns: _____

Health concerns regarding this pregnancy? _____

Client Consent

I have answered the questions on this form to the best of my knowledge and ability. I have had the opportunity to ask questions and obtain assistance. I consent to a professional and complete Chiropractic examination and to any radiographic or diagnostic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of consultation and cannot be deferred to a later date.

Patients Signature _____ Date: _____ Witnessed: _____

Chiro H3 provides an appointment reminder service by SMS and may also communicate with you by SMS and email from time to time. All clients are automatically enrolled in this service. If you do not wish to have this service please indicate below:

Please do not send me appointment reminders and communications by SMS and email.