

PAEDIATRIC INTAKE & HISTORY

CLIENT INFORMATION

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

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/Vomiting
 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)?:

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

At ChiroSports we aim to provide the highest quality care. Part of this care may involve cervical (neck) manipulation. We feel it is important that as with any health care procedure there is some risk associated with cervical manipulation. This risk is currently estimated at 1 in 1,000,000 for stroke or stroke like symptoms. This is a rare and unpredictable event. Other risks that can be associated with spinal adjustments include disc injuries, rib fractures, sprains/strains or pre-existing conditions may be aggravated. We take every precaution to ensure that risk is minimized through thorough testing, examination and the use of gentle and specific techniques. If you have any concerns, please let your chiropractor know. I acknowledge that I have been informed of the risks involved and understand that if at any time I have concerns that can be discussed with my chiropractor. I appreciate that I will receive the best care possible at CHIROSPTS but that results cannot be guaranteed. I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time or service and cannot be deferred to a later date.

Patients Signature _____ Date: _____ Witnessed: _____

ChiroSports 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.