



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

---

---

---

---

## BIRTH

The details of the birth of your child can give vital clues as to potential spinal problems. Please answer the following questions very carefully.

Was your child delivered:

Normally	Yes / No	Breech	Yes / No
Posterior	Yes / No	Premature	Yes / No
At Term	Yes / No	Caesarian	Yes / No
Late	Yes / No	Forceps	Yes / No
Chemically induced	Yes / No	Suction/Vacuum	Yes / No

Other: \_\_\_\_\_

Birth weight: \_\_\_\_\_ Apgar Scores \_\_\_\_\_

How long were you in labour? \_\_\_\_\_ Hrs How long did you "push" for? \_\_\_\_\_ Mins / Hours

Do you believe the birth was traumatic for your child? Yes / No

Was your child's head mis-shapen at birth? Yes / No

Were there any delivery complications? Yes / No

Details

---

---

---

---

## BIRTH TO SIX MONTHS

Was your child breast fed? Yes / No For how long? \_\_\_\_\_

Was your child formula fed? Yes / No For how long? \_\_\_\_\_

Did your child suffer with colic? Yes / No For how long? \_\_\_\_\_

Did your child suffer with reflux? Yes / No For how long? \_\_\_\_\_

Would you say your child was a:

Very poor sleeper Poor sleeper Average sleeper Good sleeper Very Good sleeper

## OTHER PROBLEMS

Please indicate by circling any of the following conditions which your child has experienced in the past:

Headache

Allergies

Neck Pain

Back Pain

Constipation/Diarrhoea

Earaches/Infections

Sinus Pain

Recurrent tonsillitis

Bed wetting

Recurrent Chest Infections

Growing Pains

Hyperactivity

Loss of appetite

Poor sleeping habits

Visual disorders

Constant fatigue

Arm/Leg Pain

Poor co-ordination

Learning difficulties

Recurrent stomach aches

Digestive disorders

Scoliosis

Fever

Convulsions

Joint pains

Asthma

Travel sickness

Night terrors

Seizures

Chronic Cold

Recurring Fevers

Hip Problems

Other

---

## MEDICAL HISTORY

How long did your child crawl for? \_\_\_\_\_ months

Is your child accident prone? Yes / No Has Your child had any significant falls? Yes / No

Please describe any falls or accidents your child has had.

---

---

Has your child ever been involved in a motor vehicle accident? Yes / No

Is your child on medication? Yes / No

Vaccination History? \_\_\_\_\_

Has your child had any diseases / illnesses? Yes / No

Has your child ever been hospitalised or had surgery? Yes / No

If yes, please describe: \_\_\_\_\_

---

Has your child ever had any broken bones or sprain injuries? Yes / No

If yes, please describe: \_\_\_\_\_

---

Has your child ever been assessed for the presence of scoliosis? Yes / No

Has your child had a learning disorder? Yes / No

How many times has your child taken antibiotics? In the last six months \_\_\_\_\_

During Lifetime \_\_\_\_\_

## PREVIOUS CHIROPRACTIC CARE

Has your child had previous chiropractic care? Yes / No

Reason for care \_\_\_\_\_

Date of last care \_\_\_\_/\_\_\_\_/\_\_\_\_ Name of Chiropractor \_\_\_\_\_

Location of Clinic \_\_\_\_\_ Were x-rays taken? Yes / No

How would you describe the care received? Excellent \_\_\_\_ Good \_\_\_\_ Fair \_\_\_\_ Poor \_\_\_\_