CHILD SPINAL AND POSTURAL EXAMINATION

Dear Parent,
It is our pleasure to welcome you to our clinic. Please carefully complete the following questionnaire. Your answers will help us to determine how chiropractic may benefit your child. Please note this is a postural and spinal examination *only*. No chiropractic treatment will be provided today. If treatment is required you will be advised of this and an appointment can be made for a later date.
Thank You.

Name of Child:_____ D.O.B.: ____/____/____ Age: ____

Parents Names: Father_____

Mother_____

Address: _____

_____

Contact Phone Numbers:

Home_____Mobile_____Work_____

Email _____

Other Children's Names: Have they had a previous chiropractic examination?

_____D.O.B.____/____/____ Age_____ Yes / No

_____D.O.B.____/____/____ Age_____ Yes / No

_____D.O.B.____/____/____ Age_____ Yes / No

_____D.O.B.____/____/____ Age_____ Yes / No

_____D.O.B.____/____/____ Age_____ Yes / No

How did you hear about our practice? (please circle)

Staff Member …….. Friend …….. Family …….. Internet ……..

Doctor …….. Maternal Health Nurse …….. . Other health practitioner ……..

Information in reception Y.P.'s Healthcare Class Other: ……..

Do you have private health insurance for chiropractic? Yes/ No / Unsure

Name of company_____

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

_____

_____

_____

_____

_____

PREGNANCY

Did you require any medication through your pregnancy? Yes / No ……..

Were there any complications through your pregnancy? Yes / No

_____

BIRTH

The birth of your child can give vital clues as to potential spinal problems. Please answer the following questions about the delivery and birth of your child.

Home / Hospital Delivery …….. Drugs during delivery Yes / No

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	Yes / No

Other _____

Birth weight: _____ Apgar Scores _____ _____

How long were you in labour ? _____Hours How long did you "push" for?___ Mins / Hrs

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? _____

Were there attachment issues? Yes / No Details: _____

Was your child formula fed? Yes / No For how long? _____ Type _____

Did your child suffer with colic? Yes / No If yes, how bad was it? Mild Moderate Severe

Did your child suffer with reflux? Yes / No If yes, how bad was it? Mild Moderate Severe

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	Bedwetting
Recurrent chest infections	Growing pains	Hyperactivity
Loss of appetite	Poor sleeping habits	Visual disorders
Constant fatigue	Arm/ Leg pain	Recurrent stomach aches
Scoliosis	Fever	Convulsions
Joint pains	Asthma	Travel sickness
Night terrors	Seizures	Chronic colds
Recurring fevers	Hip problems	Digestive disorders
Developmental Delay	Poor social skills	Extremely messy eater

Other _____

School Age Child:

Poor co-ordination	Learning difficulties	Poor hand writing
Behavioural Issues	Diagnosed as ADD/ADHD	Delayed verbal communication
Diagnosis of Autism	Difficulty with reading / writing / spelling	Extreme clumsiness

Other _____

MEDICAL HISTORY

What age did your child begin crawling? ……. How long did your child crawl for? ……..…

Is your child accident prone? Yes / No Has your child has 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 Details: _____

Is your child vaccinated? Yes / No

Has your child had any diseases/ illnesses? Yes / No Details: _____

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

_____

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

_____

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

How many times has your child taken antibiotics? In last six months ____ During lifetime ____

How many doses of other Prescription Medication has your child taken?

In last six months _____ During lifetime _____

What was the medication for? _____

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

Further Comments _____