Child New Patient Form

CONFIDENTIAL PATIENT INFORMATION

Welcome to Optimal Health Chiropractic! Please complete all questions and PRINT clearly. Date: …… / …… / ……

Child's Surname:	Child's First Name:
Address:	Town:
	Post code:
Home Phone:	Mobile Phone:
Birth Date: / /	Email:
Mother's Name:	Father's Name:
Brother's or Sister's Names:	
How did you hear about our practice?	

Please tick if your child's reason for attending is to improve Health & Wellness: □ or

Please list your child's complaints in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____

Is the problem getting: □ Progressively worse □ Progressively better □ Staying the same □ Comes & goes

What aggravates the condition?_____

What relieves the condition?_____

What do you think is wrong? _____

What do you think caused the problem? _____

Do your child's parents or siblings have similar problems? □ Yes □ No If yes, who: _____

Please tick if your child has had any of the following:

□ Frequent colds / infections	□ Poor concentration	□ Learning difficulties	□ Headaches
□ Cold hands / feet	□ Low energy / fatigue	□ Menstrual pain / irregularity	□ Migraines
□ Digestive problems	□ Bladder problems	□ Hot flushes / fevers	□ Asthma
□ Anxiety / Nervousness	□ Irritability	□ Allergies	□ Diabetes
□ Ulcers	□ Depression	□ Mood swings	□ Cancer
□ Poor posture	□ Low pain threshold	□ Seizures / fainting	□ Arthritis
□ Low back pain	□ Neck pain	□ Dizziness	□ Heart disease

Please list the practitioners who were consulted for these conditions:

1. _____ Diagnosis given: _____
2. _____ Diagnosis given: _____

Did you suffer from any maternal illness during the pregnancy? □ Yes □ No If yes, what: _____

How many ultrasounds did you have during the pregnancy? _____

What was your child's birth like_____

How long entire labour?_____ How long did you actually push?_____

Was the birth of your child:

□ Premature □ Due Date □ Overdue □ Induced □ Planned Caesarian □ Emergency Caesarian

□ Baby's head was pulled □ Forceps □ Ventouse □ Breech □ Face / forehead presentation

Did your child have any: □ Bruising □ Jaundice □ Special care, if yes, what: _____

Please list any operations your child has had:

1. _____ 2. _____ 3. _____

Please list any serious illnesses your child has had:

1. _____ 2. _____ 3. _____

Is your child currently on any medication? If yes, what type and what for?

_____

Has your child had any of the following vaccinations? □ DPT □ MMR □ Polio □ TB □ Meningitis

Did your child have any reactions to any of those vaccines? □ Yes □ No If yes, specify: _____

Please list any traumas, accidents, or injuries your child has had:

1. _____ 2. _____ 3. _____

What sports or recreational activities does s/he do?_____

When was the most recent stress, strain or injury while doing these activities?_____

_____

What care was given?___ _____

What is your child's sleeping pattern? _____

What is your child's eating pattern? _____

Name and address of your child's GP:_____

Has your child ever been to a chiropractor before? □ Yes □ No If yes, when? _____

Has any blood relative of your child had any of the following. If yes, please specify (who, what, when):

□ Bone or Joint disease (Arthritis / Osteoporosis) _____

□ Vascular disease (Heart disease / Stroke / Blood Pressure) _____

□ Cancer (Benign / Malignant) _____

□ Respiratory problems (Lung / Chest / Asthma) _____

□ Digestive problems (Stomach / Bowel) _____

□ Reproductive system problems _____

□ Diabetes / Metabolic disorders _____

□ Epilepsy / Nervous system disorders _____

□ Skin disorders _____

□ Allergies _____

□ Other _____

DECLARATION: This information is accurate to the best of my knowledge.

PARENT SIGNATURE: …… DATE:…… / …… / ……

CHIROPRACTOR SIGNATURE: …… DATE: …… / …… / ……

YOUR HEALTH GOALS

Name:…… **Date:** …… / …… / ……

The purpose of this questionnaire is to enable your Chiropractor to know what your health objectives are, what your expectations are and what is important to YOU.

(Please circle your answer)

Are you happy with the way you look and feel? YES NO

How long has it been since you have felt your best? Years Months Weeks

How long have you been thinking about pursuing your health goals? Years Months Weeks

What are you most interested in improving?

Overall health
Less Pains/Symptoms
Reducing Stress
Increasing your Energy and Vitality

How long do you think it will take to achieve your health goals? Years Months Weeks

Please list your desired health goals and the areas you are most interested in improving:

_____

_____

_____

Do you understand how chiropractic can help improve your overall health and well-being? YES NO

Thank you

Optimal Health
CHIROPRACTIC