CONFIDENTIAL PATIENT DETAILS

Full Name:______________________________ DOB: __________ Age:______ M ☐ F ☐
Address: ____ Postcode __________
Contact Number: ____________________ Alternate Contact: ____________________
Mother or Father Name:__________________ Siblings and Ages: ____________________
Has any of the family ever seen a Chiropractor? ☐Yes ☐No Do you still see a Chiropractor? ☐Yes ☐No

Have you noticed anything out of the ordinary with your child?____________________________

Pregnancy – Please tick all that apply to the mother

- ☐ Complications
- ☐ Medications
- ☐ Recreational Drugs
- ☐ Smoked During Pregnancy
- ☐ Alcohol
- ☐ Excessive Cravings
- ☐ Vitamins/Minerals
- ☐ Any Diagnosed Illness
- ☐ Hospitalisation
- ☐ Bleeding
- ☐ Back Pain
- ☐ Excessive Immune Deficiency

Details: ____

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Labour, Delivery and Birth – Please Tick

- ☐ Greater than 12 hours
- ☐ Fetal Monitoring
- ☐ Forceps
- ☐ Crying Constantly
- ☐ Colouring Problems
- ☐ Cesarian Delivery
- ☐ Hospital Birth
- ☐ Birthing Centre
- ☐ Home Birth
- ☐ Choking
- ☐ Cord around neck
- ☐ Complications
- ☐ Medications
- ☐ Breathing Problems
- ☐ Feeding Problems
- ☐ Premature Birth
- ☐ Jaundice
- ☐ Other ………………………………….

Details: ____

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Birth Weight:__________________Birth Length:__________________Head Circ:______________

Nutrition:

Is or was the infant ☐ Formula Fed or ☐ Breast Feeding

If Breast fed, for how long?__________ When were solids first introduced? ____________________

How much dairy food does the infant consume each day? Please list____________________

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Has the child ever been immunized? If so were there any reactions observed?____________________

General Health – Please **TICK** any conditions that the child has had in the **PAST (P)** or has **CURRENTLY (C)**.

P	C		P	C	
☐	☐	Poor Co-ordination	☐	☐	Headaches
☐	☐	Lack of Concentration	☐	☐	Leg / Arm / or Back Pain
☐	☐	Speech Problems	☐	☐	Problems with Ears or Eyes
☐	☐	Continual Colds, Cough, Throat Infections	☐	☐	Breathing / Asthma
☐	☐	Fidgets constantly / sleeping problems	☐	☐	Stomach or bowel complaints
☐	☐	Been unconscious / had convulsions / fits	☐	☐	Skin, hair, nail or tooth complaints
☐	☐	Limping or unusual walk	☐	☐	Allergies
☐	☐	Other ____________________			

Details: ____

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Development:

When did the infant walk? ____
Did they go through a good crawling phase? ______________________________

Previous Management:

What management, if anything have you tried previously? And what were the results?__________________

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***Signed Parent / Legal Guardian**______________________________Date:__________
*I have also read and signed the General Absolute Health Consent Form (if care is initiated for this infant)