livingwell CHIROPRACTIC

Chancellor Park Shopping Village
Cnr University Way & Scholars Way Sippy Downs, QLD 4556
Phone: 07 5456 1911

CONFIDENTIAL PATIENT INFORMATION

Welcome to our practice! Please complete all questions and PRINT clearly. Date:_____

Surname:	First Name: Preferred Name:	
Address:	Town/Suburb:	
	Post Code:	
Home Ph:	Mob Ph:	Guardians Work Ph:
Birth Date:		
Mums/Guardians Name:	Dads/Guardians Name:	
Do you have private health insurance? Yes/No	If yes, which fund?_____	
Whom may we thank for referring you to our practice?		

Reason for seeking chiropractic care? _____

_____

Has your child seen others Doctors for this condition? { } Yes { } No

Doctor's name and prior treatment. _____

_____

Other health problems? _____

Has your child ever suffered from: (Please check all that apply)

{ } Dizziness	{ } Backaches	{ } Heart Trouble	{ } Chronic Earaches	{ } Diabetes
{ } Tuberculosis	{ } Hypertension	{ } Colds/Flu	{ } Arthritis	{ } Headaches
{ } Asthma	{ } Allergies	{ } Neuritis	{ } Digestive Disorders	{ } Sinus Troubles
{ } Constipation	{ } Anemia	{ } Rheumatic Fever	{ } Orthopedic Problem	{ } Dioreha
{ } Poor Appetite	{ } Hyperactivity	{ } Behavioral Problems	{ } Bed Wetting	{ } Convulsions
{ } Paralysis	{ } Muscle jerking	{ } Fainting	{ } Walking Problems	{ } Broken Bones
{ } Ruptures/Hernias	{ } Neck Problems	{ } Arm Problems	{ } Leg Problems	{ } "Growing Pains"
{ } Joint Problems	{ } Blood Disorders	{ } Stomach Aches	{ } Other _____	

Family Health History: _____

Previous Chiropractor: _____ Date of last visit: _____

Reason for seeing previous Chiropractor: _____

Name of Pediatrician: _____ Date of last visit: _____

Number of doses of antibiotics your child has taken: ____ In the last 6 months _____ Total during their lifetime

Number of doses of prescription medications your child has taken: ____ In the last 6 months _____ Total during their lifetime

Vaccination History: _____

Prenatal History

Type of Birth Attendant: { } OBGYN { } Midwife { } Other _____

Location of Birth: { } Home { } Birthing Centre { } Hospital (name) _____

Complications during pregnancy: { } No { } Yes (list) _____

Ultrasounds during pregnancy: { } No { } Yes (number) _____

Medications during pregnancy and/or delivery: (including 'Gas') _____

Cigarette / Alcohol use during pregnancy: { } No { } Yes

Birth Intervention: { } Forceps { } Vacuum { } Caesarian – (Planned { } or Emergency { })

Complications during delivery: { } No { } Yes (list) _____

Genetic disorders or disabilities: { } No { } Yes (list) _____

Birth weight: _____ Birth length: _____ APGAR scores: _____

Feeding History

Breast Fed: { } No { } Yes (how long?) _____ Formula Fed: { } No { } Yes (how long?) _____

Introduced to solids at _____ months, cow's milk at _____ months.

Food / juice allergies or intolerances { } No { } Yes (list) _____

Developmental History

Number of hours sleeping per night: _____ Quality of sleep: { } Good { } Fair { } Poor

At what age was your child able to:

_____ Respond to sound _____ Respond to visual stimuli _____ Hold head up _____ Sit up

_____ Crawl _____ Stand alone _____ Walk alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs etc).
Was this the case with your child? { } No { } Yes

Is/has your child been involved in any high impact or contact type sports? { } No { } Yes (list) _____

Has your child ever been involved in a car accident? { } No { } Yes (date) _____

Has your child been seen on an emergency basis? { } No { } Yes (reason & date) _____

Other traumas not described above: { } No { } Yes (list) _____

Prior surgery: { } No { } Yes (type and date) _____

Childhood Diseases

Chicken Pox	{ } No	{ } Yes (age) _____	Mumps	{ } No	{ } Yes (age) _____
Rubella	{ } No	{ } Yes (age) _____	Whooping cough	{ } No	{ } Yes (age) _____
Rubeola	{ } No	{ } Yes (age) _____	Other (list) _____ (age) _____		

Insurance

Do you have medical insurance? { } No { } Yes (list company) _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORISATION FOR CARE OF MINOR

I hereby authorise this office and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

_____ _____ _____
(Signed) (Printed Name of Guardian) (Date)

Witnessed/Chiropractic Office Signature _____(Signature) _____(Print name and date)