BALLARAT Spinal Health
A Gonstead Chiropractic Centre

CHILD HEALTH QUESTIONNAIRE | 0-15 YEARS

The information on this form is and will remain strictly confidential.

Please read the following sections carefully and write your answer / tick where appropriate.

PATIENT DETAILS

Child's Name:_____ M / F Date of Birth:___/____/_____ Age:___
Parent / Guardian's Name:_____
Address:_____
City:_____ _____ State:_____ Postcode:_____
Telephone (Home):_____(Mobile):___ _____ _(Work):___ _____
Email:_____
Name of Paediatrician / Doctor:_____ Telephone: _____

Is your family a member of a Private Health Fund that covers Chiropractic Care? ◯ YES ◯ NO
Name of your Fund:_____
Who referred you to this Chiropractic Office?_____

Current concern with your child:_____

PRE-NATAL HISTORY (CONCEPTION to BIRTH)

While pregnant, did the mother:
Smoke / or Drink Alcohol during Pregnancy? ◯ YES ◯ NO List:_____
Take any Medications during Pregnancy? ◯ YES ◯ NO List:_____
Have Illness / Complications during Pregnancy ? ◯ YES ◯ NO List:_____
Have any falls / traumas during Pregnancy? ◯ YES ◯ NO List:_____
Have Ultrasounds During Pregnancy ? ◯ YES ◯ NO Number:_____
Duration of Pregnancy in weeks:_____ Age of Mother at time of Birth:_____

PERI-NATAL HISTORY (BIRTH)

Place of Birth: ◯ Hospital ◯ Birthing Centre ◯ Home
Provider: ◯ Midwife ◯ Medical Doctor ◯ Other
Child's Birth Weight:_____ APGAR Scores: @1min_____ @5min_____ ◯ Unsure
Type of Birth: ◯ Natural ◯ Emergency Caesarean Section ◯ Planned Caesarean Section
If not Caesarean Section, was other birth intervention required? ◯ Forceps Extraction ◯ Vacuum Extraction
Use of Drugs during birth? ◯ YES ◯ NO Was the labour chemically induced? ◯ YES ◯ NO
Complications during Delivery? ◯ YES ◯ NO List:_____
Genetic Disorders or Disabilities: ◯ YES ◯ NO List:_____

NEO-NATAL HISTORY

Immediately after Birth/During Infancy, did any of the following occur?
Need for child to be Respirated? ◯ YES ◯ NO Need for child to be in a humidicrib? ◯ YES ◯ NO
Administered medications? ◯ YES ◯ NO List:_____
Recent illness? ◯ YES ◯ NO Surgery? ◯ YES ◯ NO

Difficulty Feeding / Latching / Sucking? ◯ YES ◯ NO
Breast Fed: ◯ YES ◯ NO How Long:_____
Formula Fed: ◯ YES ◯ NO How Long:_____ Type:_____
Introduced to Solids at:_____ months, and Cows' milk at_____ months
Failure to grow/gain weight? ◯ YES ◯ NO Disrupted sleep patterns? ◯ YES ◯ NO
Hours of sleep per night:_____ Number of naps in day:_____ Length of naps in day _____
Speech or Language difficulties? ◯ YES ◯ NO

OTHER DEVELOPMENTAL HISTORY

Was your child delayed at any of the following?
Respond to Sound ◯ YES ◯ NO Respond to Visual Stimuli ◯ YES ◯ NO
Hold Head Up ◯ YES ◯ NO Sit Up ◯ YES ◯ NO Crawling ◯ YES ◯ NO
Stand Alone ◯ YES ◯ NO Walk Alone ◯ YES ◯ NO

Has your child fallen from a height? (eg bed, changing table, down stairs)? ◯ YES ◯ NO List:_____
Other Falls onto head? ◯ YES ◯ NO List:_____
Has Your Child Ever Been Involved in a Car Accident? ◯ YES ◯ NO List:_____
Has your child ever had any broken bones or sprain injuries? ◯ YES ◯ NO List:_____
Has your child been involved in high impact or contact type sports (eg, Soccer, Football, Gymnastics, Cricket, Martial Arts)?
◯ YES ◯ NO List:_____
Has Your Child Been Seen on an Emergency Basis or hospitalised? ◯ YES ◯ NO List:_____
_____
Is your child currently taking medication of any kind? ◯ YES ◯ NO List:_____
If you could improve one aspect of your child's health, what would it be? _____
_____

MEDICAL HISTORY:

Has your child experienced any of the following:

◯ ADHD/ADD	◯ Allergies	◯ Anxiety/Depression	◯ Autism/Asperger's
◯ Asthma/Bronchitis	◯ Breathing problems	◯ Back / Neck Pain	◯ Bed Wetting
◯ Blood Noses	◯ Constipation	◯ Colic	◯ Convulsions/seizures/epilepsy
◯ Coughs/Colds	◯ Developmental Delay	◯ Diarrhoea	◯ Difficult Urination
◯ Difficulty Swallowing	◯ Digestive Troubles	◯ Ear Ache/Infections	◯ Ear Infections – 2+
◯ Fatigue	◯ Failure to Thrive	◯ Fall - crib/change table	◯ Fall from play equipment/bike/tree etc.
◯ Flaking Scalp	◯ Gas	◯ Hyperactivity	◯ Headache
◯ Hearing Loss	◯ Irritability	◯ Meningitis	◯ Milk / Lactose Intolerance
◯ Muscle Tone Problems	◯ Night Pain	◯ Poor / Excess Weight Gain	◯ Rashes
◯ Reflux	◯ Sinus/Allergies	◯ Skin Rashes	◯ Sleep Issues
◯ Stomach Pains	◯ Toe Walking	◯ Unusual Movements	◯ Vision Loss

For Girls, onset of Menarche (first period): ◯ YES ◯ NO Age:_____

CHILDHOOD DISEASES

◯ Chicken Pox @ Age___ ◯ Mumps @ Age___ ◯ Rubella @ Age___
◯ Whooping Cough @ Age___ ◯ Measles @ Age___ ◯ Other (List:_____) @ Age___

CHIROPRACTIC HISTORY

Has your child had previous Chiropractic care? ◯ YES ◯ NO
If Yes, what is the name of your previous Chiropractor?_____
Where are / were they located?_____
When was the last visit / treatment?_____
Were X-Rays taken? ◯ YES ◯ NO If Yes, when?_____
Was the previous Chiropractor a Gonstead practitioner? ◯ YES ◯ NO ◯ NOT SURE
What were the results of your previous treatment?
◯ Excellent ◯ Satisfactory ◯ Fair ◯ Did Not Help ◯ Got Worse

Parental/Guardian Consent for Examination and Treatment of a Minor

I authorise for my child to be appropriately examined and treated for their condition. I understand that there are minor risks associated with Chiropractic Manipulation and that these risks are minimised by a thorough examination and the utilisation of the Gonstead System of Chiropractic. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and agree to pay the fees which have been explained to me at the time this service is rendered.

_____ / ____ / _____
Child / Patient Name (Printed) Parent / Guardian Signature Date

SYSTEMS REVIEW (Please tick the appropriate box if you currently have, or have ever had any problems with the following):

MUSCULOSKELETAL
- ◯ Neck or Back Pain
- ◯ Hip, Knee, Ankle or Foot Pain
- ◯ Shoulder, Elbow, Wrist or Hand Pain
- ◯ Swollen Joints
- ◯ Arthritis
- ◯ Weakness or Loss of Strength

EYES
- ◯ Vision Changes / Blurring / Double Vision
- ◯ Glasses / Contacts
- ◯ Dry / Watery
- ◯ Eye Pain
- ◯ Redness

EARS
- ◯ Hearing loss
- ◯ Tinnitus (Ringing), Buzzing
- ◯ Vertigo
- ◯ Pain
- ◯ Infection
- ◯ Slurred or other speech problems

NOSE
- ◯ Discharge
- ◯ Pain
- ◯ Difficulty Smelling things
- ◯ Frequent Colds / Sinusitis
- ◯ Stuffiness
- ◯ Hay Fever
- ◯ Nose Bleeds

NEUROLOGICAL
- ◯ Loss of Consciousness / Fainting / Blackouts / Seizures
- ◯ Sensory Loss / Tingling / Numbness / Weakness
- ◯ Wasting
- ◯ Headaches
- ◯ Memory problems
- ◯ Dizziness / Vertigo / Spinning
- ◯ Tremors
- ◯ Reduced Coordination
- ◯ Balance problems
- ◯ Head Injury
- ◯ Lumps or Swollen Glands

RESPIRATORY
- ◯ Chronic Cough
- ◯ Chest Pain
- ◯ Spitting up Phlegm or Blood
- ◯ Asthma or Wheezing
- ◯ Difficulty Breathing
- ◯ Tuberculosis

ENDOCRINE
- ◯ Thyroid Problems
- ◯ Heat / Cold Intolerance
- ◯ Unexplained or Weight Gain / Loss
- ◯ Excessive Thirst

CARDIOVASCULAR
- ◯ Chest Pain
- ◯ Heart illness / Arrhythmias / Irregularities
- ◯ High Blood Pressure
- ◯ Low Blood Pressure
- ◯ Blood Disorder
- ◯ Poor Circulation
- ◯ Swelling in limbs
- ◯ Varicose Veins
- ◯ Cold Hands / Feet
- ◯ Stroke
- ◯ Anaemia

MOUTH
- ◯ Pain
- ◯ Swelling
- ◯ Dryness
- ◯ Toothaches
- ◯ Bleeding Gums, Tongue / Lips

THROAT
- ◯ Infections / Sore Throat
- ◯ Bad Breath
- ◯ Difficulty Swallowing
- ◯ Swollen Glands

GASTRO-INTESTINAL
- ◯ Poor Appetite / Excessive Hunger
- ◯ Pain over the abdomen
- ◯ Difficulty Swallowing
- ◯ Nausea
- ◯ Ulcers
- ◯ Heartburn / Indigestion
- ◯ Vomiting (blood?)
- ◯ Excess Wind (Belching or Flatulence)
- ◯ Bowel Irregularity (Incontinence?)
- ◯ Food Intolerance
- ◯ Blood in Stools
- ◯ Diarrhoea / Constipation
- ◯ Haemorrhoids (piles)
- ◯ Jaundice / Anaemia
- ◯ Chronic Fatigue

GENITO-URINARY (General)
- ◯ Bed Wetting
- ◯ Kidney Infections
- ◯ Frequent Urination
- ◯ Difficulty Urinating
- ◯ Incontinence
- ◯ Blood in Urine
- ◯ Burning with Urination
- ◯ Excessive Urination at night
- ◯ Prostate troubles
- ◯ Discharge

GENITO-URINARY (Females Only)
- ◯ Cramps or Back pain
- ◯ Painful Menstruation
- ◯ Irregular Menstruation
- ◯ Absence of Menstruation
- ◯ Hot Flashes
- ◯ Excessive Flow
- ◯ Vaginal discharge
- ◯ Swollen Breast
- ◯ Lumps in Breasts
- ◯ Discharge
- ◯ Pregnant
- ◯ Difficulty Conceiving

SKIN
- ◯ Eczema
- ◯ Psoriasis
- ◯ Lumps / Bumps / Swelling
- ◯ Bruise easily
- ◯ Mole Changes
- ◯ Rashes and/or Itching
- ◯ Acne
- ◯ Dryness
- ◯ Colour changes
- ◯ Temperature changes

PSYCHOLOGICAL

◯ Stress ◯ Anxiety ◯ Depression
◯ Nervousness ◯ Difficulty Coping ◯ Counselling?

OTHER HEALTH PROBLEM:

BALLARAT Spinal Health
A Gonstead Chiropractic Centre

INFORMED CONSENT TO CHIROPRACTIC CARE

The information on this form is and will remain strictly confidential.

Chiropractic care is recognised as being an effective and safe method of care for many conditions. However, you must recognise that there are risks associated with all health care procedures which you should be informed about.

Please read the following carefully

1. I acknowledge that I have discussed with my Chiropractor, the rare risks associated with my proposed care which include but are not limited to muscle and joint soreness or strains, nausea and dizziness, fractures, disc injuries including disc encroachments/ruptures, causing nerve irritation and referred symptoms, strokes (or like episodes) and an exacerbation and/or aggravation of my underlying condition. Such risks may result in outcomes such as referral, further tests, surgery, incapacity and the like. *In very rare circumstances, some treatments of the neck may damage a blood vessel and lead to stroke or related symptoms (current statistics eg between 1 in 2 million to 1 in 5.85 million -Haldeman, et al. Spine vol 24-8 1999). Other possible risks include strain/injury to a ligament or a disc in the neck (current statistics eg less than 1 in 139,000) and the low back (current statistics eg 1 in 62,000 Dvorak study in Principles & Practice of Chiropractic, Haldeman 2nd Ed.). For some patients especially with bone weakening diseases, a fracture of a bone although rare is possible."*
2. I also acknowledge the following additional potential risks insofar as my proposed care is concerned have been explained to me.
   Details:_____
   _____
3. I have had the opportunity to discuss the proposed care with my Chiropractor. I also acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed Chiropractic care and that I have been given sufficient time to make a decision giving consent for the care to proceed.
4. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.
5. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
6. I hereby acknowledge my consent to the performance of the proposed Chiropractic care by my Chiropractor and/or any other Chiropractor working in this clinic. I understand that I can withdraw consent at any time.
7. I give this clinic permission to use my postal address to send me birthday cards and thank you cards. I also give permission for my children who are under Chiropractic care to have their photograph displayed in this clinic, if the child desires.

_____ _____

Patient Name (Printed) Patient Signature
(Parent or Guardian must sign if patient under 18years of age)

_____ _____

Chiropractor Name (Witness) Chiropractor Signature

____ / ____ / _____
Date

BALLARAT SPINAL HEALTH
423 Ascot St, South Ballarat VIC 3350
T: (03) 4333 9488 | E: admin@ballaratspinalhealth.com.au | W: www.ballaratspinalhealth.com.au
ABN: 44 885 537 685