

File Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Office Use)

Here at Fremantle Chiropractic, our goal for anyone we accept under our care is to help you live your best life. Whether that’s helping to reduce pain or discomfort, alleviating various symptoms, improving function or restoring health, we are here to help.

For us to fully understand why you are here, your child’s overall state of health and to make sure you’re in the right place, we have a series of questions for you below. We appreciate you filling this form out to the best of your ability. Thank you, and welcome!

**Your Childs Details**

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Given Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents Names:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (M)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who recommended you to us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Preferred Method of Contact:  Phone  SMS  Email

**How Can We Help You?**

**What is your main concern with your childs health?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Past** | **Present** |  |  | **Past** | **Present** |  |  | **Past** | **Present** |  |
| Ear Disorder/Infections |  |  |  | Unusual Head Shape |  |  |  | Poor posture |  |  |  |
| Behavioural Problems |  |  | Birth Trauma |  |  | Asthma |  |  |
| Hyperactivity |  |  |  | Growing Pains |  |  |  | Arm and Leg Pain |  |  |  |
| Stomach Ache |  |  |  | Learning Difficulties |  |  |  | Recurrent infection |  |  |  |
| Irritability |  |  | Back Pain |  |  | Bet Wetting |  |  |
| Colic |  |  | Dyslexia |  | Fatigue |  |  |
| Trouble Sleeping |  |  |  | Migraine |  |  |  | Poor Co-ordination |  |  |  |
| Gastric Reflux |  |  |  | Vision Problems |  |  |  |  |  |  |  |
| Breast Feeding Issues |  |  |  | Digestive disorders |  |  |  |  |  |  |  |
| Torticollis |  |  |  | Scoliosis |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
|  | **Brief Details** |
| **PREGNANCY** |  |
| Where there any problems throughout the pregnancy? |  |
| Please list any Medications take during pregnancy:  |  |
| Any infections/illnesses during pregnancy? |  |
| **BIRTH** |  |
| Any interventions: eg: suction, forceps, caesarean, episiotomy |  |
| Any complications? |  |
| Do you believe the birth was traumatic for the child? |  |
| Medications during labour |  |
| How long was the first stage of labour? |  |
| How long was the pushing phase? |  |
| How long were you in hospital after birth? |  |
| **NEONATE/INFANCY** |  |
| What was the Apgar score after birth? |  |
| Was your child breast fed? If so, how long? |  |
| If your child is currently on formula, please name: |  |
| Any developmental delays? |  |
| Is your child crawling? Did your child crawl? |  |
| Did you child suffer from colic or reflux? |  |
| Did your child suffer from constipation |  |
| **DIET** |  |
| Any Allergies? |  |
| How often is cows milk consumed? |  |
| How much bread, cereals, potatoes per day? |  |
| What medications does/has your child taken? |  |
| **ILLNESSES/INFECTIONS** |  |
| Any illnesses/infections/injuries? Please list: |  |
| 0-1yrs |  |
| 1-2yrs |  |
| 2-3yrs |  |
| 3-4yrs |  |
| 4-5yrs |  |

Our health is often dependent on things that have happened in the past. Has your child ever had:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **No** | **Yes** | **Age** | **Brief Details** |
| A car accident |  |  |  |  |
| A broken bone  |  |  |  |  |
| Been knocked unconscious or a fall from >1m |  |  |  |  |
| Any major Illness  |  |  |  |  |
| Been hospitalised or surgery |  |  |  |  |
| Any other physical or emotional trauma |  |  |  |  |

**Please outline your child’s feeding and sleeping patterns:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Your Goals and Health Objectives:**

What are your goals for your child with us? (Tick any that apply)

\_\_\_\_\_ Short-term relief of symptoms

\_\_\_\_\_ To correct the underlying cause of my symptoms and health issues

\_\_\_\_\_ To prevent development of symptoms and health problems in the future

\_\_\_\_\_ To achieve an optimum level of health and well-being (ie. Live life to the fullest!)

Any others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_