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(6-15)

Child's Name: _____ Date: _____ Referred By:_____

Address:_____City:_____ Post Code:_____

Date of Birth:_____ Age:_____ Gender: M / F

Mother's Name: _____Mobile No:_____ Home Phone:_____

Father's Name: _____Mobile No:_____ Home Phone:_____

Primary Contact Email Address: _____

Names and ages of siblings: _____

GP's Name: _____ Address: _____

When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your child's care here, if relevant? Y / N

History of Present Illness

Is your visit for wellness care? Y/N If Yes, skip to **Past & Current Health History**

Specific concern: _____

When did this begin? _____ How did it originally occur? _____

Is the concern: Getting Better _____ Same _____ Getting Worse _____

If able, describe the concern: Sharp _____ Dull _____ Numb _____ Tingling _____ Achy _____
Other _____

Is this concern: Constant _____ Frequent _____ Intermediate _____ Occasional _____

Does anything relieve the problem? Y/N If Yes, what? _____

Does anything make it worse? Y/N If Yes, what? _____

Previous doctors & treatments: _____

Please rate the pain of the problem, if relevant:

1 – No Hurt 2 – Hurts a little 3 – Hurts a lot 4 – Hurts worst

Past & Current Health History

Please check each of the following your child has currently, or has had in the past:

___ Measles/Mumps
___ Chicken Pox
___ Eczema/Skin Problems
___ Pneumonia
___ Asthma/Wheezing
___ Cancer
___ Hepatitis
___ Allergies
___ Frequent colds/sore throat
___ Diarrhoea
___ Constipation
___ Colic
___ Ear infection
___ Tonsilitis
___ Back pain
___ Headaches
___ Dizziness
___ Fainting
___ Seizures/Convulsions
___ Anaemia
___ Bed Wetting
___ Behavioural problems
___ ADD/ADHD
___ Ruptures/hernia
___ Growing pains
___ Sleep problems
___ Speech problems
___ Emotional problems
___ Nightmares
___ Co-ordination problems
___ Stomach Aches
___ Reflux
___ Diabetes
___ Heart Trouble
___ Orthopaedic problems
___ Neck Pain
___ Joint problems/pain
___ Scoliosis
___ Walking trouble
___ Broken bones
___ Digestive disorder
___ Poor appetite
___ Fever
___ Hip/leg pain
___ Concentration problems

Please list any allergies: _____

Please list any medications your child is currently taking: _____

Please list any supplements/vitamins your child is currently taking: _____

Number of doses of antibiotics your child has taken in his/her life: _____

Has your child ever suffered from the following spinal traumas?

___ Been in car accident
___ Broken bones
___ Concussion
___ Sports Injuries
___ Fall from bed or couch
___ Fall off swing
___ Fall off slide
___ Fall off monkey bars
___ Fall off skateboard or skates
___ Fall off bicycle
___ Fall down stairs
___ Other: _____

Date of last visit to paediatrician: _____ Purpose of visit: _____

Has your child ever been treated on an emergency basis? Y/N Details:_____

_____

Did you choose to vaccinate your child? Y/N
If Yes, which vaccines? All/None If a few, please list: _____

Please list any hospitalisations, surgeries or traumas: _____

_____

_____

Lifestyle & Diet

What sports do you play? _____

What hobbies do you have? _____

How many hours each day do you watch TV? _____

How many hours each day do you spend using a computer? _____

How often do you play video games? _____

On average, how many hours of sleep do you get each night? _____

Do any of your friends or family smoke? _____

Do you feel stressed out? _____

Do you have trouble reading the board in class? _____

Do you sometimes get headaches when you read? _____

Do you have trouble paying attention in school? _____

What do you usually eat for breakfast? _____

_____

What do you usually eat for lunch? _____

_____

What do you usually eat for dinner? _____

_____

What kind of snacks do you usually eat? _____

What is your favourite food? _____

How many fizzy drinks or tea/coffee do you drink each day? _____

In your tea/coffee, do you add any: Milk _____ Sugar _____ Sweeteners _____

How often do you eat fast food? _____

Print Name:

_____

I can confirm that the above is a full and accurate disclosure of my child's health and medical status.

Signature_____ Date_____

I authorise Dr Arleen Scholten DC to examine and adjust my child's spine/extremities/cranium as she deems appropriate, (or a locum doctor authorised by Dr Arleen Scholten, in her absence) through the use of Chiropractic methods.

Signature: _____Date: _____