Office use only:	Patient # _____________ Date: ____/____/______

McMillan Chiropractic Centre

Thank you for allowing us to be involved in the improvement of your Health & Wellbeing!

It is *essential* that you complete all the following questions to the best of your ability. These questions are all relevant to your child's health & our proposed Chiropractic care plan. Failing to provide information at this point could affect your child's ability to respond to treatment & even place your child's health at risk from inappropriate treatment being provided.

It is a pleasure to welcome you to our clinic. To help us serve you better, please take the time to complete **all** the following information.

Child's name: ____ Child's D.O.B. ___________________

Address: ____ Phone No. __________________________

Mother's Name: ______________________ Phone (H) __________________ Phone (W) ___________________

Father's Name: ___________________ ____ Phone (H) ___________________ Phone (W) ___________________

Would you prefer SMS or phone CALL reminders? SMS / CALL

Who is responsible for making appointments? Mother / Father / Other ____________________________________

Other Children's names: (Please include their birthdates and gender.) ____________________________________

____

____

How did you hear of this clinic? ____

What concerns do you have regarding the health of this child? (Your reason for contacting us?)

____

____

YOUR CHILD'S HEALTH HISTORY (*The situations surrounding the birth of your child can give us vital clues regarding their potential spinal problems, so please answer all the following questions carefully.)*

Did you have any problems during Pregnancy? Yes / No Details:____

____

____

Was your child delivered?

At home	◻	Posterior	◻	Forceps	◻
Birthing Centre	◻	Premature	◻	Suction / Vacuum Extraction	◻
Hospital	◻	At Term	◻	Chemically Induced	◻
Normally	◻	Late	◻	Other: _______________________	
Breech	◻	Caesarean	◻		

Birth Weight: ________________ Apgar Scores: _______________ Length of Labour: ____________

How long did you "push" for?________________ Mins/hours

Do you believe the birth was traumatic for the child? Yes / No

Was the child's head misshapen at birth? Yes / No

Was there any delivery complications? Yes / No Details: ___________________________

BIRTH TO 6 MONTHS

Is/was your child breastfed? Yes / No For how long? ______________________

Is/was your child formula fed? Yes/ No For how long? ______________________

What type? ______________________

Is/was your child colicky? Yes / No How badly? Mild / Moderate / Severe

Does/did your child suffer reflux? Yes / No

Number of hours sleep per night: __________ hours. Quality of sleep: Good / Fair / Poor

Explain / details: ______________________

SYMPTOMS

Please tick if your child has ever suffered any of the following:

Headaches	◻	Tonsillitis	◻	Hyperactivity	◻
Travel sickness	◻	Growing/back pains	◻	Stomach Aches	◻
Learning difficulties	◻	Visual changes	◻	Asthma	◻
Allergies	◻	Sleep problems	◻	Temper tantrums	◻
Seizures	◻	Ear Infections	◻	Eczema	◻
Recurring fevers	◻	Bed wetting	◻	Colic	◻
Scoliosis	◻	ADHD	◻	Digestive problems	◻
Chronic Colds	◻				

MEDICAL HISTORY

Has your child ever taken Antibiotics? Yes / No When and how long for? ______________________

Has your child ever taken other prescription medication? Yes / No When? ______________________

Is your child currently taking any medication? Yes / No Details:______________________

Vaccination History: ______________________

Has your child ever been hospitalised / had surgery? Yes / No Details & Dates: ______________________

____

How long did your child crawl for? __________ Months. Is your child accident prone? Yes / No

Has your child had any significant falls? Y / N Details: ______________________

____

Please list accidents (significant) and dates they have had (including car accidents etc.):______________________

____

Has your child suffered any diseases / illnesses? Yes / No Details: ______________________

____

Does your child suffer any learning disorder? Yes / No Details: ______________________

____

Has your child ever been assessed for scoliosis? Yes / No Results & Dates: ______________________

____

PREVIOUS CHIROPRACTIC CARE

Has your child been to a Chiropractor before? Yes / No If yes, whom? ______________________

What was the reason for this care? ______________________

____

Date of last adjustment? ______________________ Were any X-Rays taken? Yes / No

How would you describe the care your child received? Excellent / Good / Fair / Poor