

# THE WELLNESS PLACE

## Confidential Patient Form



The completion of this form is a sensible first step prior to experiencing the many benefits associated with chiropractic. This form has been designed to assist with delivering the most appropriate chiropractic treatment and/or identifying any possible risk factors to your health and safety to provide appropriate care and advice.

### ABOUT YOUR CHILD

Child's Name: \_\_\_\_\_

Child's Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

School Attended: \_\_\_\_\_

Referred By: \_\_\_\_\_

### FAMILY INFORMATION

Parent's Name: \_\_\_\_\_

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

Address: \_\_\_\_\_

Please list any other children (including birth date):

\_\_\_\_\_  
\_\_\_\_\_

How did you hear about us?       Referral       Yellow Pages       Signage      Other \_\_\_\_\_

### **YOUR CHILD'S HEALTH HISTORY**

Reason for today's visit: \_\_\_\_\_

Type of birth:      Normal Vaginal            Caesarean            Home        
                                 Vacuum Extraction            Forceps            Hospital     

Problems during pregnancy; labour; delivery: \_\_\_\_\_

Congenital anomalies / defects: \_\_\_\_\_

Vaccination History: \_\_\_\_\_

Is your child uncomfortable sleeping in any particular position?

\_\_\_\_\_

Number of hours your child sleeps per night? \_\_\_\_\_      Quality of sleep: GOOD-----  
-----POOR

Does your child feed better from one side? \_\_\_\_\_

Last visit to GP: \_\_\_\_\_ Purpose: \_\_\_\_\_

According to the US National Safety Council, approximately 50% of all children have fallen from a high place during their first year of life (eg. Bed, change tables, stairs) Is this the case with your child? \_\_\_\_\_

As the legal guardian, I hereby give my permission for this clinic and its Doctor to administer care as they so deem necessary to this child.

.....  
**Parent or Guardian Signature**

Date: .....

## THE CHILD'S SYMPTOMS IN THE LAST 12 MONTHS

- |  |  |                                    |
|--|--|------------------------------------|
| <input type="radio"/> Low Back Pain            | <input type="radio"/> Digestive Troubles   | <input type="radio"/> Headaches    |
| <input type="radio"/> Sleeping Disorder        | <input type="radio"/> Ear/Throat Infection | <input type="radio"/> Fatigue      |
| <input type="radio"/> Hyperactivity            | <input type="radio"/> Meningitis           | <input type="radio"/> Constipation |
| <input type="radio"/> Milk/Lactose Intolerance | <input type="radio"/> Loss of Hearing      | <input type="radio"/> Neck Pain    |
| <input type="radio"/> Asthma                   | <input type="radio"/> Allergies            | <input type="radio"/> Cold/Flu     |
| <input type="radio"/> Breathing Problems       | <input type="radio"/> Irritability         | <input type="radio"/> Blood Noses  |
| <input type="radio"/> Diarrhea                 | <input type="radio"/> Bed Wetting          | <input type="radio"/> Colic        |
| <input type="radio"/> Sinus Problems           | Other: _____                               |                                    |

## THE CHILD'S CURRENT CONDITION

- |  |   |   |   |
|--|---|---|---|
| Is your child accident prone?                                  | Y | N |   |
| Has the child had any falls down steps?                        |   | Y | N |
| Has your child ever fallen from heights of over 2 feet?        |   | Y | N |
| Has your child ever been involved in a motor vehicle accident? |   | Y | N |
| Has your child ever been hospitalized or had surgery?          |   | Y | N |
| Has your child ever had broken bones or sprain injuries?       |   | Y | N |
| Has your child a learning disorder?                            |   | Y | N |
| Has your child poor posture?                                   | Y | N |   |
| Is your child on medication of any kind?                       |   | Y | N |

If yes please specify: \_\_\_\_\_

Has your child had a spinal curvature (scoliosis) examined by a qualified Practitioner? Y    N

Does your child show signs of nervousness, twitching, excessive talking to themselves? Y    N

If you could improve one aspect of your child's behavior, what would it be?

Relevant Family History: \_\_\_\_\_

Please note that any and all information, written or otherwise, that you give us is strictly confidential and is so treated by the entire staff. No information or records will be released to any person, health fund, insurance company or any Doctor without the written permission of the patient.

I believe the information above is correct to the best of my knowledge.

.....  
**Parent or Guardian Signature**

Date: .....