CONFIDENTIAL ***CHILD CASE HISTORY***
SPINAL & POSTURAL
EXAMINATION FORM

Bundilla Family
CHIROPRACTIC

Dear Parent

It is our pleasure to welcome you to our practice. Our team is dedicated to providing and promoting Wellness Chiropractic Care for families.
To enable us to assist with your family's health goals and determine whether chiropractic can help your child, please complete the following Confidential Case History Form.

Surname:_____ First Name:_____
D.O.B. __/_ _/__ Age:

Parents Names: Father: _____

Mother: _____

Address: _____

City: _____ State: _____ P/Code: _____

Ph: Home: _____ Mobile: _____
Work: _____ Email: _____

Other Children's Names:

_____ D.O.B.__/__/__ Age: _____

_____ D.O.B.__/__/__ Age: _____

_____ D.O.B.__/__/__ Age: _____

_____ D.O.B.__/__/__ Age: _____

Have you or your child had previous chiropractic care? Yes / No

Name of previous Chiropractor? _____ Last visit: _____

Reason for child's care: _____

X-rays: Yes / No What was X-rayed and when _____

Do you have private Health Insurance for Chiropractic? Yes/ No
Health Fund: _____

Please read the following information on 'This Practice and your Privacy'

From 21st December 2001, new privacy laws apply in Australia that regulate the way the Practice handles your personal information. These laws give you new rights, such as your right to access personal information held about you and the right to correct it if needed. The new laws also state how the Practice may collect, disclose, store and keep safe your personal information.

To enable the Practice to continue to deliver and enhance the products and services it provides, this Practice holds personal information about you.
We recognize and support your right to privacy in relation to this information and will continue to handle it with care and in accordance with our professional and legal requirements.

The Practice staff will continue to demonstrate integrity and understanding by protecting and keeping secure your personal information.

We ask that you read the Practice's ***'Privacy Statement'.*** We invite you to contact our Privacy Officer if you would like to discuss this matter further.

If you wish to know more information about our handling practices you may ask us about our ***'Privacy Policy'.***

_____

I understand that this clinic does not hold accounts and that all fees are payable at the time of the visit.

I have read the section regarding my personal information and understand this clinic's position on patient privacy.

Who is responsible for the child's fees ? _____

Signature: _____
Parent / Guardian signature

Name of Parent/ Guardian: _____

Date: __ / __ / __

What concerns do you have regarding your child ?

_____

_____

_____

_____

BIRTH

The birth of your child can give vital clues to potential spinal and health problems. Please answer the following questions very carefully.

Was your child's birth delivery:

Normal	Yes / No	Breech	Yes / No	Posterior	Yes / No
Premature	Yes / No	At Full Term	Yes / No	Caesarian	Yes / No
Late	Yes / No	Forceps	Yes / No	Induced	Yes / No
Suction / Vacuum	Yes / No				

Other: _____

Birth weight: _____ Apgar Scores: _____ _____

How long were you in labour? _____

How long did you 'push for'? _____ mins / hours

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

Was your child's head mis-shapen at birth? Yes/ No

Were there any delivery complications? Yes/ No

Details _____

BIRTH TO SIX MONTHS

Was your child breast fed ? Yes / No For how long ?_____

Was your child formula fed ? Yes / No For how long ?_____

Did your child suffer with colic ? Yes / No
If yes, how bad was it ? Mild / Moderate / Severe

Did your child suffer with reflux ? Yes / No
If yes, how bad was it ? Mild / Moderate / Severe

Would you say your child was a:
Very poor sleeper
Poor sleeper
Average sleeper
Good sleeper
Very good sleeper

OTHER PROBLEMS

Circle any of the following conditions that your child previously or currently suffers from:

Loss of appetite	Asthma	Recurring Fevers
Allergies	Growing Pains	Headache
Travel Sickness	Neck Pain	Constipation
Diarrhoea	Sinus Pain	Hyperactivity
Recurrent Chest Infections	Visual Disorders	Arm Pain
Poor Sleeping Habits	Earaches/ Infections	Constant Fatigue
Recurrent Tonsillitis	Poor Co-ordination	Digestive Disorders
Learning Difficulties	Recurrent Stomach Aches	Scoliosis
Dizziness	Joint Pains	Epilepsy
Hip Problems	Seizures	Back Pain
Convulsions_	Bedwetting	

Other: _____

MEDICAL HISTORY

Medical Doctors name: _____ Last visit: _____

List any medications your child is taking: _____

Are there any illnesses that run in your family ? _____

Has your child had any diseases/ illnesses ? Yes / No _____

_____

Vaccination History ? _____

How long did your child crawl for ? _____ months

Is your child accident prone ? Yes / No
Has your child had any significant falls ? Yes / No

Has your child ever been involved in any motor vehicle accidents ? Yes / No

Has your child ever been hospitalized or had surgery ? Yes / No

Please describe: _____

Has Your child ever had any broken bones or sprain injuries ? Yes / No

Please describe: _____

Has your child ever been assessed for the presence of scoliosis ? Yes / No

Has your child had a learning disorder ? Yes / No