GLOBAL
HEALTH CENTRE
CHIROPRACTIC

CHILDRENS INFORMATION SHEET

Name of Child: ____ D.O.B____/____/____ Age: ______
Parents Names: Father: __________________________Mother: ____

Address: ____
____Postcode:___________

Contact Phone Numbers
Home: ________________________Mobile:___________________________ Work: ________________________
Email: ____
Other Children's Names:
____ D.O.B ____/____/____ Age________
____ D.O.B ____/____/____ Age________
____ D.O.B ____/____/____ Age________
____ D.O.B ____/____/____ Age________

WHO REFERRED YOU TO OUR CLINIC?
FRIEND (Name) __________________________ NEWSPAPER YELLOW PAGES
MEDICAL DOCTOR CHIROPRACTOR SINGAGE OTHER

Do you have private health insurance for chiropractic? Yes / No / Unsure
Name of company ____

What concerns do you have regarding the health of your child?
Major_Complaints;____
____
Other_Complaints;____
____
How long has the child had this condition? ____
Previous Diagnosis/Treatment ____
____

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

Was your child delivered:

Normally Yes / No	Breech Yes/ No	Posterior Yes / No
Premature Yes / No	At Term Yes / No	Caesarian Yes / No
Late Yes / No	Forceps Yes / No	Chemically Induced Yes/ No
Suction/Vacuum Yes / No		

Other ____
Birth Weight: ____________________________ Apgar Scores_______ ________

How long were you in labor for? ____________ Hours 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? ___________ Type_______
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
Please indicate by circling any of the following conditions which your child has experienced in the past:

Headache	Allergies	Neck Pain
Back Pain	Constipation/ Diarrhoea	Earaches/ Infections
Sinus Pain	Recurrent Tonsillitis	Bedwetting
Recurrent chest infections	Growing Pains	Hyperactivity
Loss of appetite	Poor sleeping habits	Visual Disorders
Constant fatigue	Arm/ Leg pain	Poor co- ordination
Learning difficulties	Recurrent stomach aches	Digestive disorders
Scoliosis	Fever	Convulsions
Joint pain	Asthma	Travel sickness
Night Terrors	Seizures	Chronic Colds
Recurring Fevers	Hip Problems	

Other____

MEDICAL HISTORY
How long did your child crawl for? ________months
Is your child accident prone? Yes / No Has your child has any significant falls? Yes / No
Please describe any falls accidents your child has had.
____
____
Has your child ever been involved in a motor vehicle accident? Yes / No
Is your child on medication? Yes / No
Vaccination History? ____
Has your child had any disease/ illnesses? Yes / No
Has your child ever been hospitalized or had surgery? Yes / NoIf yes, please describe:
____
____
Has your child ever had any broken bones or sprain injuries? Yes / No If yes, please describe:
____
____
Has your child ever been assessed for the presence of scoliosis? Yes / No
Has your child had a learning disorder? Yes / No
How many times has your child taken antibiotics? In last six months____ During lifetime___
In last six months_____ During Lifetime______

PREVIOUS CHIROPRACTIC CARE
Has your child had previous chiropractic care? Yes / No
Reason for care____
Date of last care ___/___/___ Name of Chiropractor____
Location of Clinic ____________________________ Were X-rays taken? Yes / No
How would you describe the care received? Excellent______ Good _______Fair ______Poor ______

CONSENT TO TREATMENT OF A MINOR
I here by authorize Dr Andrew Norwood and whoever he may designate as his or her assistants to administer Chiropractic care as deemed necessary to my child.

Name of Child: ______________________________
I understand and agree that health and accident insurance policies are an arrangement an insurance carrier and myself. Furthermore, I understand that Chiro Health Works will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment to Chiro Health Works.

____ ___________________________
Signature (Parent/Guardian) Today's Date