healthy for life
chiropractic bournemouth

Welcome to our office

Our chiropractic mission is to enable you to be the best you can be.

New Client Details Form For Children (from 6m to 16yrs)

Child's Surname: Age:

Child's Forename(s): DOB:

Parent / Caregiver's Name:

Address:

Home Tel: Work Tel:

Mobile: Email:

No & Age of siblings:

How did you hear about us? (If recommended, by whom?)

Name and Practice of GP

YOUR BODY IS DESIGNED TO BE HEALTHY. If it is not, there is always a cause or reason. Throughout life many events occur that may affect your health.

The following questions will help your Chiropractor assess any layers of dysfunction, particularly to your child's nervous system, that may have adversely affected your child's health.

Please tick and complete where appropriate. All information will be handled in the strictest confidence.

Your Pregnancy

A Mum's health during her pregnancy can have an influence on the health of the child.

During your pregnancy did you:

O Have back pain O Have pubic pain O Any other pains: _____
O Have high blood pressure O Have diabetes O Have bleeding O Excess vomiting
O Smoke O Drink Alcohol O Drink Caffeine O Take any medication/drugs
O Take folic acid O Take fish oil O Take a pro-biotic O Experience high levels of stress

The Birth

The birth process can be quite traumatic for mother and baby and is often where spinal dysfunction first occurs.

Was the birth:

O Unassisted O Forceps / Suction O Caesarean O Short duration O Premature
O Induced O Breech O Drug assisted O Prolonged labour O Distressed

Feeding History

Difficulties with sucking, latching on and positional preference may be indicative of spinal dysfunction.

Is / was your child:

O Breast fed For how many weeks/months? _____
O Bottle fed Which formula? _____
O Mixed Proportion? _____

If breast fed does / did your child latch on and suck evenly on both sides? Yes / No

_____

As a baby, did your child vomit large quantities of their feeds?

_____

Does your child suffer from constipation or diarrhoea? _____

Sleeping History

How many hours per night does your child sleep? _____
Does your child still sleep during the day? _____

Immunisation History

Has your child had the routine immunisations?

O yes O No

Did your child have any adverse reactions?

O yes O No

Details: _____

Health History

Does your child suffer from:

O Colic	O Measles	O Ear infections	O Behavioural problems
O Allergies	O Mumps	O Tonsillitis	O ADHD
O Eczema	O Rubella	O Recurrent colds	O Dyslexia
O Asthma	O Chicken Pox	O Chest infections	O Clumsiness
O Food intolerance	O Fatigue/tiredness	O Urinary tract infections	O Headaches
O Tummy ache	O Diabetes	O Bedwetting	O Visual problems
O Jaw clicking	O Rapid weight loss	O Joint problems	O Loss of consciousness
O Dental work	O Cancer	O Hearing loss	O Epilepsy/fits/seizures

Did your child:

O Crawl before walking	O Use a baby walker	O Use a baby bouncer
O Have a chair pulled from under them	O Fall down stairs	O Sleep on their stomach
	O Bang their head	

Girls

Has your daughter started having periods? Yes / no
If yes, at what age did they start? _____
Are they regular? _____
Does she experience period pain? _____
Is your daughter taking the Oral Contraceptive Pill? Yes / No

Accident History

Has your child at any time suffered:

O Broken Bones	Age & Details: _____
O Motor Vehicle Accidents	Age & Details: _____
O Unconsciousness	Age & Details: _____
O Other Significant trauma	Age & Details: _____

Medical History

Has your child ever suffered an illness requiring long-term hospitalization/medication? Yes / No
Details:_____ Age:_____

Does your child take any medication? O Yes O No

Medication:	Reason	Duration
_____	_____	_____
_____	_____	_____

Has your child had any surgery? O Yes O No

O Tonsils O Appendix O Adenoids O Grommets
O Other _____

Has your child ever had x-rays, scans or MRI (please give details and dates)? _____
_____

Is there a family history of:

O Heart disease O Stroke O Arthritis O Cancer O Diabetes

Nutrition

Does Your child:

Drink Water	O 0–1 glass per day	O 2–3 glasses per day	
	O 4–8 glasses per day	O more	
Eat <u>fresh</u> vegetables	O 0–3 servings per week	O at least 1 per day	O several per day
Eat <u>fresh</u> fruit	O 0–3 servings per week	O at least 1 per day	O several per day
Drink fizzy drinks	O 0ccasionally	O 0-3 per week	O every day
Eat sugary foods	O 0ccasionally	O 0-3 per week	O every day

Other Stresses

Which sports, hobbies or leisure activities does your child engage in?_____

_____

_____

Is your child exposed to significant stress at:

School	O Yes	O No
Home	O Yes	O No

Current Health

What aspects of your child's health currently concern you? _____

_____

_____

_____

Is your child currently suffering any pain?
(Please describe & indicate the location on the diagram)

_____
_____
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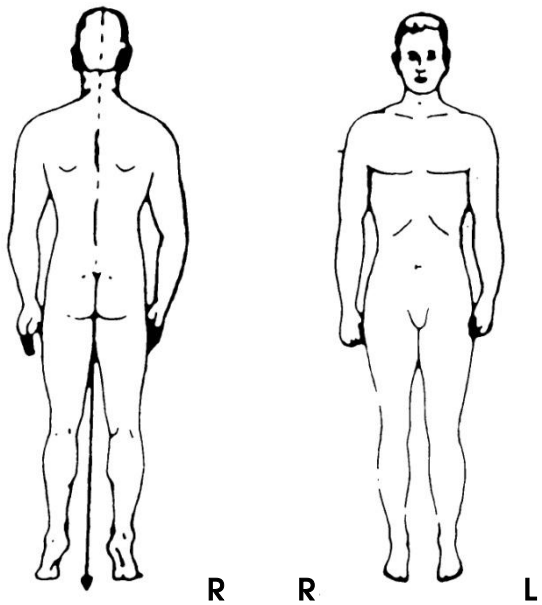

Thank you for taking the time to complete this form.