Wellness & Vitality
CHIROPRACTIC

Welcome to Wellness & Vitality Chiropractic

Research shows that poorly moving spinal joints can affect how the brain controls and co-ordinates the body's ability to respond to its environment (1). The chiropractor will assess your child for spine and nervous system function and, after a careful history and examination, explain if your child has a chiropractic problem. Please answer these questions thoroughly and to the best of your knowledge.

To enable us to assist you in your child's health goals please complete the following:

Full Name of Child:	
Address: Postcode:	
Date of birth:	Age:
Has your child ever received chiropractic care? Yes ❑ No ❑ From Whom? When?	
Name of Parent/Guardian:	
Contact details for Parent/Guardian:	
Home phone:	Work phone:
Mobile phone:	Email address:
Who may we thank for referring you?	
I understand that I am liable for fees incurred and that payment is at the time of service. Signed: Date: (Parent/Guardian)	
GP and Surgery Address:	

YOUR CHILD'S HEALTH

Your child's body is designed to be healthy. Throughout life, events can occur which may damage their health expression. This case history will help uncover those potential layers of damage, especially to your child's spine and nervous system, and determine how their health has been affected. Following an examination a course of care will be outlined which will aim to restore normal spine function to help improve your child's ability to regulate themselves in their environment. (1)

PLEASE TRY TO ANSWER THES FOLLOWING QUESTIONS AS BEST YOU CAN, EVEN YOUR CHILD IS OLDER. THIS PROVIDES IMPORTANT INFORMATION TO ASSIST THE CHIROPRACTOR'S ASSESSMENT.

LOSS OF WELLNESS (BIRTH – AGE 5)

Often the causes of health problems occur in early years.

Maternal Health in Pregnancy

Did you:	**Yes**	**No**
Have morning sickness?	❑	❑
Smoke or drink alcohol?	❑	❑
Have a proper diet?	❑	❑
Exercise through pregnancy?	❑	❑
Have any other tests, e.g. amniocentesis?	❑	❑

If yes, please describe: _____

Have any ultrasound scans? ❑ ❑

How many? _____ How long did they last? _____

Take any medication during your pregnancy (include homeopathic remedies, supplements)

If yes, please describe: _____

Please describe any problems/injuries you had during your pregnancy, however minor:

Did your pregnancy:	**Yes**	**No**	
Go to term?	❑	❑	How many weeks? _____

Birth Process:	**Yes**	**No**
Was your delivery long?	❑	❑
Was your delivery difficult?	❑	❑
Intervention, e.g. Forceps/Ventouse	❑	❑
Caesarean	❑	❑
Breech	❑	❑
Home Birth	❑	❑
Hospital Birth	❑	❑
Induced Labour	❑	❑
Drugs used in Delivery	❑	❑

Obvious signs of injury after birth (e.g. bruising, skin damage, cephalohaematoma).
If yes, please describe:

_____

Baby and Childhood

Growth and Development

	Yes	No
Were they a headbanger?	❑	❑
Have they ever fallen on their head?	❑	❑
Have they ever fallen downstairs?	❑	❑
Were they taught how to care for their spine?	❑	❑
Did they ever have a chair pulled from under them?	❑	❑

Sleep

	Yes	No
Do they sleep well?	❑	❑
Are they swaddled when they sleep?	❑	❑

Do they sleep on their ❑ front ❑ back ❑ side

Feeding

	Yes	No	
Are/were they breast fed?	❑	❑	If yes, for how long? _____
Do/did they feed better to one side?	❑	❑	If yes, which side? _____
Do they feed efficiently and well?	❑	❑	

Does/did mum suffer from any discomfort, breast or nipple problems _____

	Yes	No
Do they suffer any food allergies or intolerances?	❑	❑

If yes, please describe

_____

Nappies

How often do they fill their nappies? _____ What colour is it? _____

Do they struggle to poo or pass wind? _____

Other Childhood Accidents/hospitalisations? If yes, please describe

_____

_____

Please list any vaccinations: _____

Did they suffer any reaction to any of the vaccinations given?
If yes, please tick any of the relevant reactions below:

□ fever □ convulsions □ irritability □ asthma/allergies □ sleeping difficulties
□ ear infections □ eating difficulties □ Autism/learning difficulties □ Local swelling at injection site
□ Other? If yes, please describe:

Other Childhood Medication:

_____

_____

DEVELOPMENTAL MILESTONES

Please indicate the most complex skill that your child can perform in each section

Gross Motor Skills

AGE	SKILL	TICK
4 weeks	Able to hold head up from table momentarily	
3 months	Can push up head and shoulders when lying on stomach	
4 months	Can be pulled into sitting position by hands	
4-5 months	Rolls from front to back & back to front	
6 months	Sits unsupported in upright position	
6 months	When on stomach can push up onto hands	
9 months	Crawls	
9 months	Stands holding onto furniture	
11 months	Walks with someone holding onto one hand	
12 months	Walks unassisted	
2 years	Runs	
2 years	Climbs stairs placing 2 feet on each step	
3 years	Climbs stairs using 1 foot on each step	
4 years	Walks downstairs with 1 foot on each step	
4 years	Hops on 1 foot	
4 years	Skips	

Social Skills

AGE	SKILL	TICK
2 months	Able to make eye contact & smiles	
3 months	Reaches for familiar objects	
4 months	Plays with hands	
6 months	Plays with feet	
9 months	Clearly shows joy and pleasure	
12 months	Feeds with fingers	
15 months	Plays peek a boo	
18 months	Understands yes/no	

Fine Motor Skills

AGE	SKILL	TICK
At birth	Grasps finger with hand	
4 months	Holds and shakes rattle placed in hand	
5 months	Reaches for objects	
6 months	Moves an object from one hand to another	
6 months	Self-feeding, can hold and eat food in hand	
6 months	Puts object in mouth	
12 months	Picks up objects with thumb and index finger	
15 months	Turns 2-3 pages of a book at time	
18 months	Turns pages of a book one at a time	
18 months	Builds a tower with 5 blocks	
3 years	Builds a tower with 10 blocks	

Communication Skills

AGE	SKILL	TICK
7 weeks	Makes cooing sounds	
3 months	Laughs	
5 months	Uses one syllable words such as –da	
8 months	Uses 2 syllable words such as –da –da	
12 months	Uses 2-3 word vocabulary	
24 months	Uses 2-3 word phrases	
3 years	Uses 3-5 word phrases	

Adaptive Skills

AGE	SKILL	TICK
10 months	Feeds from a cup unassisted	
12 months	Holds own bottle	
2 years	Feeds self with utensils	
3 years	Able to identify and match some colours	
3 years	Copies a circle	
4 years	Copies a cross	

SCHOOL AGE CHILDREN

Do you have concerns with your child's:

	Yes	No
Coordination	❑	❑
Balance	❑	❑
Speech and Language	❑	❑
Social Skills	❑	❑
Learning	❑	❑
Exercise Tolerance	❑	❑
Sleep Habits	❑	❑

Activities

Are they clumsy or co-ordinated? **yes** □ **no** □

Please describe any learning difficulties

_____

Do they play sports? yes □ no □ If yes, what_____

Have they suffered any sporting injuries? yes □ no □ If yes, please describe

_____

Please describe any current health issues or concerns

_____

_____

_____

AGE 5 – PRESENT

Have they suffered or do they suffer from any of the following:

Past	Present		Past	Present		Past	Present	
❑	❑	Epilepsy	❑	❑	Shoulder Pain/Stiffness	❑	❑	Frequent Urination
❑	❑	Dizziness	❑	❑	Hand Pain	❑	❑	Bedwetting
❑	❑	Headaches	❑	❑	Finger Numbness/Tingling	❑	❑	Menstrual Difficulties
❑	❑	Sinusitis	❑	❑	Nausea	❑	❑	Low Back Pain/Stiffness
❑	❑	Migraines	❑	❑	Heartburn/Indigestion/Reflux	❑	❑	Hip Joint Stiffness
❑	❑	Ear Disorders	❑	❑	Colic	❑	❑	Buttock Pain
❑	❑	Eye Disorders	❑	❑	Allergies	❑	❑	Leg Pain
❑	❑	concentration issues	❑	❑	tonsillitis	❑	❑	hoarse voice
❑	❑	swallowing problems	❑	❑	conjunctivitis	❑	❑	rashes
❑	❑	growing pains	❑	❑	fatigue	❑	❑	fainting
❑	❑	loss of consciousness	❑	❑	stomach aches	❑	❑	Leg Numbness/Tingling
❑	❑	Jaw Pain/Clicking	❑	❑	Asthma	❑	❑	Arm Pain
❑	❑	Mid Back Pain	❑	❑	Recurrent Sore Throats	❑	❑	Kidney Pain
❑	❑	Cancer	❑	❑	Hernias	❑	❑	Other
❑	❑	Neck Stiffness/Pain	❑	❑	Constipation	❑	❑	……
❑	❑	Arthritis	❑	❑	Diarrhoea			……

MY REASONS FOR CONSULTING THIS CLINIC ARE:

_____

_____

PATIENT CONSENT - CHILD

As a regulated health profession all chiropractors must warn patients of potential material risks associated with their treatment.

Published cases of serious adverse events in infants and children receiving chiropractic therapy are rare (2,3). Chiropractors are trained to modify their treatment to suit the age and presentation of the child and special styles of very gentle treatment are used for babies and young children. A thorough history and examination is performed to minimize any risk involved with the care provided and to determine if co-management or referral to another health professional is warranted.

The most common complaints in infants and children after chiropractic treatment are stiffness or soreness, and restlessness or increased crying. These effects, if they occur, can be expected to last less than 24 hours following treatment.

If you have any questions related to the treatment your child is to receive, please speak to the chiropractor.

I also acknowledge the personal information I provide will be treated confidentially by the practitioners and staff of this practice and that no external third party can access this information without my written consent.

I am the parent or legal guardian of (child's name) _____

I understand I have had an opportunity to discuss the above information with the chiropractor and give my consent to examination and treatment.

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____ Date: _____
(To be signed and dated at the first appointment)

Chiropractor's Name: _____

Chiropractor's Signature: _____ Date: _____

DATA PRIVACY CONSENT

We would like you to confirm whether you are happy for us to leave messages if we need to contact you.

a. I am happy for you to contact me *(please tick all that apply)*
   - ☐ On home phone (messages can be left with a family member)
   - ☐ On mobile
   - ☐ On work phone
   - ☐ By email
   - ☐ I do not wish to be contacted about appointments

b. On occasion we may like to make you aware of events or information that we feel may be of interest to you via email. Please tick below if you do not wish to receive this information.

   - ☐ I do not wish to be contacted about events, or information

I have read the privacy policy and understand how Wellness & Vitality Chiropractic will store and use my information.

I understand that I can opt not to receive information from the clinic at any time.

Signed: _____ Print Name: _____

Date: _____

1. Haavik, H. Murphy, B. Exploring the neuromodulatory effects of the verterbral subluxation and chiropractic care. CJA 40 (1) 2010
2. Vohra, S., et al., *Adverse events associated with pediatric spinal manipulation: a systematic review.* Pediatrics, 2007. **119**(1): p. e275-83)
3. Todd, A. Carroll, M. Robinson, A. Mitchell, E. Adverse events in infants and children from chiropractic and other manual therapies JMPT 2014