Tasman Bay Chiropractic

Child Health History Form

CONFIDENTIAL

Personal Details

Given Names:_____ Surname: _____

Address:_____

_____ Postcode: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ *E-mail: _____

Emergency Contact (EC) Details: EC Name: _____

EC Phone: _____ Relationship to child: _____

Birth Date: _____ Age: _____ Ethnicity _____

(for ACC)

Is your child covered for chiropractic care by health care insurance? Yes [ ] No [ ]

If Yes, by whom? _____ Is this an ACC Claim? Yes [ ] No [ ]

Who is your child's regular doctor (General Practitioner)? _____

We are grateful that our practice grows by referral. How did you hear about us? Who may we thank for referring you? _____

Has your child seen a chiropractor before?

Yes [ ]: who did they see and when was their last visit? _____

_____

No [ ] We will explain everything as we go and only proceed once you and your child are completely comfortable.

Please complete the information on the following pages as accurately as possible, as it will help us in evaluating the function of your child's spine and nervous system.

**will be used to send our quarterly newsletter to and for correspondence regarding your care*

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Please circle the purpose for your child's visit today: crisis management/prevention/ wellness/early detection of problems/maximizing normal growth and development

If the purpose of your visit today is wellness care please go to page 4 – Medical History and General Health section.

Major Health Concern

What is your child's main issue? _____

_____

When and how did it start? _____

Was there any of the following prior to or during the onset? (Please circle)

-Illness / infection

-Trauma / accident

- Other significant event

Is the problem getting better, worse or does it come and go? _____

What relieves your child's symptoms? _____

_____

What makes their symptoms worse? _____

_____

Are symptoms worse at night or any specific time of the day? _____

_____

Do you know if they have any pain traveling down their arms or legs? Yes/No If yes, describe:

_____

Does their current problem involve any of the following? If Yes, where?

- Tingling in either arm or leg No/Yes:_____
- Numbness in either arm or leg No/Yes:_____
- Weakness in either arm or leg No/Yes:_____
- 'Weird' sensations in either arm or leg No/Yes:_____

Has your child had any other treatment for their current problem?

No/Yes:_____

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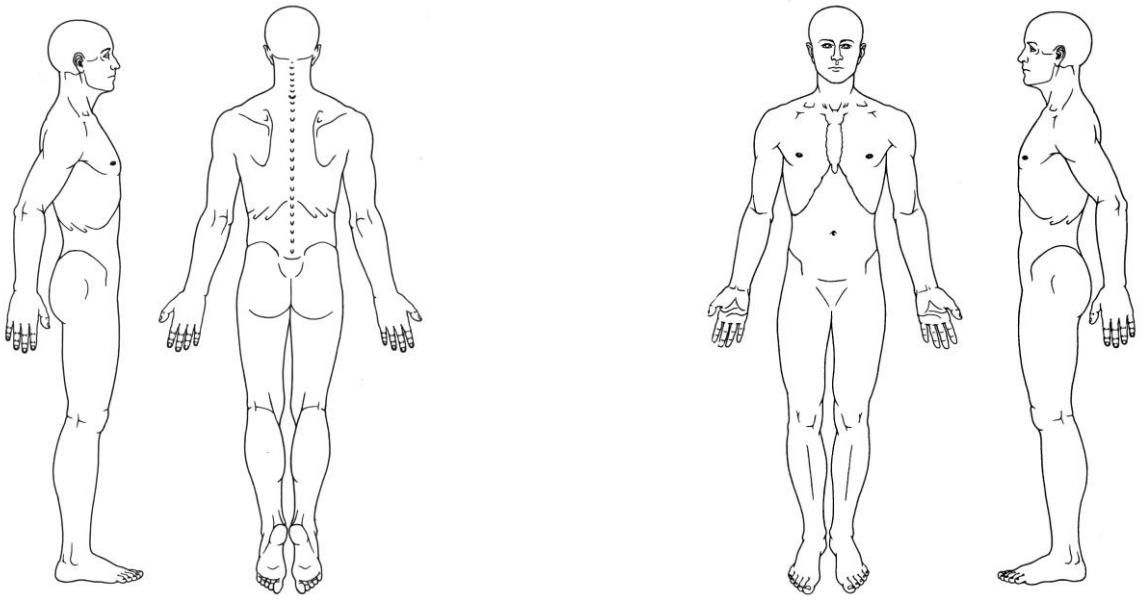
Where is the Problem?

If you or your child knows where there may be a problem, please indicate this on the diagram.



Please tick if your child may have had any of the following:

headaches		chest pressure		weight loss	
dizziness		chest pain		weight gain	
irritability		frequent colds		dental problems	
fatigue		sinus congestion		fevers	
depression		sore throats		heart palpitations	
loss of balance		ear pain/infections		numbness in feet	
loss of concentration		asthma		numbness in hand(s)	
fainting		cold sweats		weakness	
ears buzzing		bronchitis		heartburn	
poor coordination		pneumonia		muscle cramps	
vision changes		difficulty breathing		upper back pain	
loss of memory		shortness of breath		neck pain	
loss of smell		allergies		low back pain	
loss of taste		constipation		radiating pain	
light sensitivity		diarrhoea		sleeping problems	
face flushed		urinary problems		numbness in leg(s)	
reduced mobility		bloating/gas		stiffness	

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Medical History and General Health

Please circle Yes or No where applicable:

Has your child had any form of surgery? Yes/No If yes, where and when?

_____

Is your child currently taking any form of medication? Yes/No

If yes, please list all of them and state the reason for taking it

_____

Has your child broken any bones? Yes/No If yes, which ones and how?

_____

Has your child been involved in any motor vehicle accidents (no matter how trivial)? Yes/No If yes,

when and describe: _____

Has your child had any falls or sports injuries? Yes/No If yes, when and describe:

_____

Family Health History

Please note any health problems (eg: cancer, hereditary conditions, diabetes, heart disease) that are present in:

Mother's family _____

Father's family _____

Sibling(s) _____

Stressors

Since problems that chiropractors look for and detect can be related to many types of stressors, our chiropractor may ask some questions about stressors.

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Authorising Consent for examination of a Minor (under 16 years)**:** Please Read Carefully

In order for the chiropractor to make a determination on the suitability of my child's/guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation.

I have had the opportunity to discuss with the chiropractor, or with any party authorised to do so by that chiropractor, the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the chiropractor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated to best practices delivered in the child's interest.

Our practice specialises in managing functional problems and associated disorders of the nervous system with a focus on neuro-musculoskeletal complaints. A proportion of our patients come via referral from their medical practitioner and/or from a previous chiropractor. As such, it is standard practice to correspond with medical practitioners where appropriate and/or to request notes and any x-rays from previous chiropractors.

Please complete the following:

☐ I give consent for my child's clinical information to be communicated to their general practitioner and/or another registered health provider where appropriate.

☐ I give consent for Tasman Bay Chiropractic to request notes and any x-rays from my child's previous chiropractor(s).

_____
(Signature)

_____
(Print Name)

_____
(Date)

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CONSULTATION AND EXAMINATION

H.H.

Lifestyle ☐ NTR

Radiation History ☐ NO ☐ YES

Previous Treatment ☐ NO ☐ YES

Handedness ☐ L ☐ R **B+B** ☐ NTR ☐ YES ☐ MAIGNES

FAMILY HISTORY

☐ Cancer ☐ Arthritis ☐ NTR

☐ Heart / Vascular disease ☐ Diabetes ☐ Serious illness

Standing

	L	R	RE EX L	RE EX R	RE EX L	RE EX R
C. Rotation 70⁰						
C. Flex 45⁰						
C. Ext 45⁰						
Kemp's C						
C. Lat Flex 40⁰						
Trunk Flex 90⁰						
Trunk Ext 30⁰						
Kemp's L						
Trunk Lat Flex 35⁰						
Trunk Rot 30⁰						
Serratus Antr						
Deltoid						
Supraspinatus						
Opponens						
Latisimus						
Rombergs						

Weight						
Height						
BP						
Pulse						

Sitting

Upper Traps						
Scalenes						
C. Compression						
Jacksons						
Valsalva						
SLR Sitting						
Brachioradial C 5, 6						
Biceps C 5, 6						
Triceps C 7, 8						
Patella L 2, 3, 4						
Ankle S 1, 2						
Babinski						

Supine

	L	R	RE EX L	RE EX R	RE EX L	RE EX R
Psoas						
Quadriceps						
Piriformis						
Neck Flexors						
Pectoralis						
Abdominal						
SLR						
Fabere Patrick						
SOT Cervical						

Prone

Derifield						
Elys						
Hamstring						
Gluteus						
Leg / Hip Extension						
Neck Extensors						

PATIENT

L	0	R
	1	
	2	
	3	
	4	
	5	
	6	
	7	
	1	
	2	
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	
	11	
	12	
	1	
	2	
	3	
	4	
	5	
	S	

CHIRO

L	0	R
	1	
	2	
	3	
	4	
	5	
	6	
	7	
	1	
	2	
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	
	11	
	12	
	1	
	2	
	3	
	4	
	5	
	S	

TOTAL + VE TESTS

EXAM ☐ Date:

☐ Date:

☐ Date: