Here at Waters Family Chiropractic, our goal for anyone we accept under our care is to help you live your best life. Whether that's helping to reduce pain or discomfort, alleviating various symptoms, improving function or restoring health, we are here to help.

For us to fully understand why you are here, your child's overall state of health and to make sure you're in the right place, we have a series of questions for you below. We appreciate you filling this form out to the best of your ability. Thank you, and welcome!

Your Childs Details

Surname: _____ Given Names: _____

Parents Names:_____

Address: _____ Suburb: _____ Postcode: _____

Phone: (M)_____ (W)_____ (H) _____

Email: _____ Date of Birth: _____

Age: _____ Weight: _____ Height: _____

Who recommended you to us?_____

Your Preferred Method of Contact: ▫ Phone ▫ SMS ▫ Email

How Can We Help You?

What is your main concern with your childs health?

_____

_____

	Past	Present
Ear Disorder/ Infections		
Behavioural Problems		
Hyperactivity		
Stomach Ache		
Irritability		
Colic		
Trouble Sleeping		
Gastric Reflux		
Breast Feeding Issues		
Torticollis		

	Past	Present
Unusual Head Shape		
Birth Trauma		
Growing Pains		
Learning Difficulties		
Back Pain		
Dyslexia		
Migraine		
Vision Problems		
Digestive disorders		
Scoliosis		

	Past	Present
Poor posture		
Asthma		
Arm and Leg Pain		
Recurrent infection		
Bet Wetting		
Fatigue		
Poor Co-ordination		

	Brief Details
PREGNANCY	
Where there any problems throughout the pregnancy?	
Medications taken during pregnancy:	
Any infections/illnesses during pregnancy?	
BIRTH	
Any interventions: eg: suction, forceps, caesarean, episiotomy	
Any complications?	
Do you believe the birth was traumatic for the child?	
Medications during labour	
How long was the first stage of labour?	
How long was the pushing phase?	
How long were you in hospital after birth?	
NEONATE/INFANCY	
What was the Apgar score after birth?	
Was your child breast fed? If so, how long?	
If your child is currently on formula, please name:	
Any developmental delays?	
Is your child crawling? Did your child crawl?	
Did you child suffer from colic or reflux?	
Did your child suffer from constipation	
DIET	
Any Allergies?	
How often is cows milk consumed?	
How much bread, cereals, potatoes per day?	
What medications does/has your child taken?	
ILLNESSES/INFECTIONS	
Any illnesses/infections/injuries? Please list:	
0-1yrs	
1-2yrs	
2-3yrs	
3-4yrs	

4-5yrs	

Our health is often dependent on things that have happened in the past. Has your child ever had:

	No	Yes	Age	Brief Details
A car accident				
A broken bone				
Been knocked unconscious or a fall from >1m				
Any major Illness				
Been hospitalised or surgery				
Any other physical or emotional trauma				

Please outline your child's feeding and sleeping patterns:

Your Goals and Health Objectives:

What are your goals for your child with us? (Tick any that apply)

_____ Short-term relief of symptoms

_____ To correct the underlying cause of my symptoms and health issues

_____ To prevent development of symptoms and health problems in the future

_____ To achieve an optimum level of health and well-being (ie. Live life to the fullest!)

Any others: _____