Child Chiropractic Welcome Form

PLEASE PRINT CLEARLY

CHILD'S 1ST NAME:____ DOB:___/__/____ AGE:_____

CHILD'S SURNAME:___________________ FATHER'S FULL NAME:___________________________

MOTHER'S FULL NAME:____

ADDRESS:____

HOME PH NO: _____________________ MOBILE CONTACT NO:_______________________

PARENT'S EMAIL ADDRESS: ___________________________

PEDIATRICIAN/GP NAME AND ADDRESS:____

____

BIRTH WEIGHT:_______________ CURRENT WEIGHT:_____________ CURRENT HEIGHT:________

NAME AND AGES OF SIBLINGS:____

____

HOW DID YOU HEAR ABOUT OUR CLINIC?____

PRIVATE HEALTH FUND NAME:___________________________ NUMBER:_____________________

PATIENT HEALTH INFORMATION:

MAIN HEALTH CONCERN(S)____

IS THE PROBLEM (CIRCLE): PROGRESSIVELY GETTING WORSE/STAYING THE SAME/GETTING BETTER/

CONSTANT/FREQUENT/OCCASIONAL?

HAS YOUR CHILD BEEN TREATED FOR THIS CONDITION? YES / NO

IF SO WHEN?____

Obstetrical procedures can cause tractioning and twisting of an infant's spine, producing **Vertebral** Subluxation (a spinal bone which has lost its normal position and range of motion causing irritation to delicate nerve tissue).

TYPE OF BIRTH (circle all that apply) VAGINAL / FORCEPS / BREECH / C-SECTION / HOME / HOSPITAL

BIRTHING CENTRE / OTHER: ____

WHAT WAS THE GESTATION PERIOD FOR YOUR CHILD? ____________________________________

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Liforce Pty Ltd T/A Helena Valley Chiropractic
ACN: 117424807

HOW LONG WAS THE ENTIRE LABOUR? ____

PROBLEMS / COMPLICATIONS DURING PREGNANCY / DURING LABOUR / DELIVERY? _____________

____

INFANT FEEDING (CIRCLE): BREAST / BOTTLE / FORMULA – IF FORMULA, WHAT TYPE? ____________

QUALITY OF SLEEP: GOOD / FAIR / POOR – HOURS PER DAY: _________ HOURS PER NIGHT: _______

IMMUNIZATIONS: YES / NO – SPECIFY: ____

COVID VACCINE: YES/ NO – DATE GIVEN: ____

SURGERY AND / OR MEDICATIONS: ____

MOST RECENT FALL: ____

OTHER SIGNIFICANT FALLS / TRAUMA / MOTOR VEHICLE ACCIDENT(S): ________________________

SPORTS AND RECREATIONAL ACTIVITIES: ____

Vertebral subluxation *can cause irritation to different nerves that can affect any organ or tissue, causing conditions now or in the future.*

Has your child ever suffered from:

ADHD	Allergy	Asthma	Bed Wetting	Broken Bones
Back Pain	Colic	Headache	Neck Pain	Digestive Problems
Tonsillitis	Scoliosis Sleeping Problems		Growing Pains	

Otis Media (ear infection) Other ____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this clinic and its Doctor(s) to oversee care as the so deem necessary to my son / daughter / ward (upon approval of parent or guardian)

RELATIONSHIP: ___________________________ SIGNATURE: ______________________________

CANCELLATION POLICY

It is our aim to provide high quality, timely treatment at all times. To assist us in this matter, if you are unable to attend please call **48 hours before Chiropractic Homeopathy or Massage appointment**. NB: **A cancellation/missed appointment fee of 50% of the Scheduled Appointment Fee may be charged if this notice of change of appointment is not given.**

A newsletter will be provided for any relevant advice or updates to our practice which you may unsubscribe at any time.
PAYMENT: Payment on the day by Cash or Eftpos only. This Clinic DOES NOT RUN ACCOUNTS.

I, _______________________________ have read and fully understand the above statements and accept chiropractic care for my child on this basis.

SIGNATURE: ______________________________ DATE: ___/___/______

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