Patient Questionnaire: Child 0-12 years

General Information

Full Name: _____ Gender: M/F/Non-Binary

Date of Birth: _____ Address: _____

_____Post Code:_____

Guardian 1 Name: _____ Ph: _____

Email: _____Relationship: _____

Guardian 2 Name: _____ Ph: _____

Email: _____Relationship: _____

General Practitioner Who/Where: _____

How did you find out about Health Matters? Signage ☐ Internet ☐ Facebook ☐ Previous Clinic ☐

Personal Reference: _____

Has the child been to a chiropractor before? Yes/No

If yes, who with and when was their last adjustment? _____

How can we help your child today?

Major symptom/concern: _____

When/how it begun: _____

Do you feel that it is: ☐ Getting better ☐ Staying the same ☐ Getting worse ☐ Unsure

Do you feel your child is developing & reaching milestones at a similar time to their peers?

Yes/No If No, please explain: _____

Do you have any concerns about the following? Please circle:

Moods/Reactions	Head shape/Asymmetry	Poor Posture
Learning difficulties	Sleep problems	Achieving milestones
Co-ordination & balance	Poor neck movement/position	Muscle tone
Crawling/walking	Hip/leg/knee/foot problems	Digestion/feeding

Other: _____

_____

_____

Is the child currently under the care of other healthcare professionals? Yes/No

Name: _____ Profession: _____

Name: _____ Profession: _____

Name: _____ Profession: _____

Is your child currently on any medications or supplements? Yes/No

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

Pregnancy History

You might be wondering why we need to know about the mother's health and her pregnancy. We believe that the future health of a child begins prior to conception and throughout pregnancy.

Sleep, mood and stress can play a major role in hormone fluctuations, rest, repair and growth	Activity, posture, physical stress and accidents can impact foetal position and labour outcomes	Nutritional quality, medicine. drugs & environmental exposures affect a babies developing nervous system
What were the mother's average stress levels during pregnancy? LOW 1 2 3 4 5 HIGH	How much did you exercise during pregnancy? (3 x a week = 3) NONE 1 2 3 4 5 LOTS	Vegetable consumption during pregnancy. (4 serves p/day = 3) LOW 1 2 3 4 5 HIGH
Was IVF used to conceive? YES/NO	Any accidents, falls or car accidents? YES/NO	Morning sickness? NONE 1 2 3 4 5 LOTS
Fear about labour? NONE 1 2 3 4 5 LOTS	Experience of back pain NONE 1 2 3 4 5 LOTS	Cravings or avoidances? NONE 1 2 3 4 5 LOTS
Amount of emotional stress NONE 1 2 3 4 5 LOTS	Did you participate in pregnancy yoga? YES/NO	Did you have any vaccinations? YES/NO
Did you experience any depression? YES/NO	Did you participate in jolting spots, Eg, Netball: YES/NO	Cigarette use/exposure NONE 1 2 3 4 5 LOTS
Did you experience any anxiety? YES/NO	Did you have a physically active job? YES/NO	Alcohol exposure (daily = 5) NONE 1 2 3 4 5 LOTS

Did you feel supported by friend/family? LOW 1 2 3 4 5 HIGH	How many hours sitting per day? <5hs 6-9hs 10-14hs 15+hs	Drug exposure, specifically, recreationa YES/NO

Any details you feel we should know about the mother's health before or during pregnancy:

_____

_____

_____

Father's History at Conception

Fathers provide 50% of the DNA that determines your child's genetic makeup. DNA can be affected by a variety of lifestyle factors. The following questions are about the father's health and habits **at the time of conception**:

What were the father's average stress levels during the pregnancy? LOW 1 2 3 4 5 HIGH	How much did he exercise beforehand? (3 x a week = 3) NONE 1 2 3 4 5 LOTS
Did he experience any anxiety or depression? YES/NO	Any x-rays or chemotherapy in the past? YES/NO
Vegetable consumption beforehand. (4 serves p/day = 3) LOW 1 2 3 4 5 HIGH	In the 2 months prior to conception did he use cigarettes, alcohol or drugs? YES/NO

Extra details you feel we should know about the father's health during/prior to conception?

_____

Birth History

Being born is a big deal! Your child's birth experience impacts their body's activation and initial acclimatisation to the world. These factors may explain some symptoms/behaviours.

Fear & exhaustion interrupt the body's normal labour progression	Most interventions cause stress on the child's neck, body and head	Drugs used during labour may cross the placenta and affect your baby
How was the mother's stamina during labour? LOW 1 2 3 4 5 HIGH	Child's position during labour: Head Down, Brow, Posterior, Breech	Rate your child's alertness after birth LOW 1 2 3 4 5 HIGH
Was blood pressure a concern? YES/NO	Were any of the following used: Forceps Vacuum Forceful pulling	Were any of the following used? Epidura Spinal Block Spinal Anesthesia Gas

Please describe your child's birth, including any details of medical intervention and why:

_____

_____

_____

Birth Weight: _____ kgs Birth Length: _____ cm Head Circumference: _____ cm

Weeks Gestation: _____ Did your child experience foetal distress? YES/NO
Did your child need intensive care after or during birth? YES/NO
What was your child's APGAR score? Immediately at birth: _____ @ 3minutes: _____

Were any of the follow an issue:

Facial Bruising ☐ Odd head shape ☐ Bloodshot eyes ☐ Swelling ☐ Jaundice ☐
How long was the mother in active labour for? _____
If your child was born via C-Section, was your child engaged beforehand? YES/NO
If born in hospital, how long did you and your child stay in hospital? _____

Health History During the First 6-8 Weeks

Every newborn relies on involuntary in-built reflexes to feed, react to exposures, sleep, wake and cry for help. These reflexes are produced by the nervous system and are the same for every baby.
If reflexes are altered we know the nervous system has been upset during pregnancy or birth.

Please circle answers about your child immediately after birth:

Did baby recover well after birth? YES/NO	What was baby's first meal? Breast Milk Formula	Did your child sleep well after birth? YES/NO
Did baby arch their head or neck? YES/NO	Was skin-to-skin contact experienced? YES/NO	Did baby hold their head in a particular way? YES/NO
Were Vit K or any vaccines given after birth? YES/NO	Did your child wake itself to feed? YES/NO	Did your child cry when changing positions? YES/NO
Did your child have to take any medications? YES/NO	Was your child diagnosed with clicky hips? YES/NO	Were there renovations /painting at home? YES/NO
0-14 days, how long was their sleep? <1h 1-2hrs 2-3hrs 3+hrs	Did baby have certain postural habits when awake or sleeping? YES/NO	Did your child experience colic, reflux c persistent crying? YES/NO
Did the mother need medical support immediately after labour? YES/NO	Did any smokers hold or care for your baby frequently? YES/NO	What was baby's muscle tone like? FLOPPY STIFF AVERAGE TIGHT

Any further details you would like to note: _____

_____

Health History from 2 months to 12 months

What medications/antibiotics have been used, for what condition and how frequently?

_____

_____

Any hospital visits or stays? YES/NO Details: _____

_____

_____

_____

Has your child received the standard vaccinations? YES/NO

Any alterations to the schedule? _____

Any reactions to any vaccinations or medications ? YES/NO Details: _____

_____

After the first 6-8 weeks we find that some families start to get into routines and tend to get out and about a little more. During the first year of life a child's body and brain is growing rapidly from learning from the world around them. Understanding what their environment was like, how they reacted and coped, their milestones and health history, gives us information about their nervous systems health and development.

Sleep, moods, thoughts & emotional stress	Development, posture, activity levels & physical stress	Nutrition, environment & immune system function
Did the mother experience any post-natal depression? NO YES	When out of the home what item did you use mostly? PRAM SLING BABY CARRIER ARMS	What did your child mainly drink/eat 2 months? Breast milk Formula Both
Did your child have difficulty sleeping NO YES	Did your child like tummy time? NO YES	Experience ear infections or tonsillitis NO YES
Did your child make eye contact regularly? NO YES	Did they do greater than 20 minut tummy time a day? NO YES	Any fevers of 39 degrees or higher? NO YES
Did your child bang their head frequently? NO YES	Did they reach milestones at simil times to their peers? NO YES	Any skin rashes, eczema or dermatitis? NO YES
Did your child have quick changes in temperament? NO YES	Has your child fallen from a height above knee level or bumped their head firmly? NO YES	Any colic, reflux, persistent crying, g or tummy distension? NO YES
Did your child prefer to play alone? NO YES	Has your child been in a car accident or near miss? NO YES	Frequent colds or flus (more than 2 per year)? NO YES

Details? _____

_____

_____

Development & Movement

When did they begin to use words?_____

When did your child start to sit on its own? _____

Did they have difficult crawling properly?_____

When did they begin to walk?_____

Do you have any other details you feel we should know?_____

_____

_____

_____

_____

Health History from 1 year to 12 years

Has your child ever had? Measles ☐ Mumps ☐ Chicken Pox ☐ Glandular Fever ☐

Other: _____

What medications/antibiotics have been used, for what condition and how frequently?

_____

_____

Any hospital visits or stays? YES/NO Details: _____

_____

_____

_____

Has your child received the standard vaccinations? YES/NO Covid Vaccination? YES/NO

Any alterations to the schedule? _____

Any reactions to any vaccinations or medications ? YES/NO Details: _____

_____

_____

_____

Please circle YES or NO in relation to the following:

Sleeping problems YES/NO	Balance Problems YES/NO	Allergies YES/NO
Hard to wake or very tired YES/NO	Body pain in arms or legs YES/NO	Chronic colds/flus (4+ p/year) YES/NO
Does not cope well with stress YES/NO	Many major injuries or falls YES/NO	Ear infections or tonsillitis YES/NO
Fatigue YES/NO	Problems walking YES/NO	Recurrent fevers YES/NO
Temper tantrums YES/NO	Clumsy/trips/falls YES/NO	Anaphylaxis YES/NO
Quick mood change YES/NO	Oculo-motor problems YES/NO	Eczema YES/NO
Gets frustrated easily YES/NO	Bed Wetting YES/NO	Asthma YES/NO
Anxiety YES/NO	Motion Sickness YES/NO	Frequent dark circles YES/NO
ADHD/ Autism YES/NO	Any major learning difficulties YES/NO	Respiratory tract infections YES/NO
Head banging YES/NO	Scoliosis YES/NO	Food intolerances and sensitivities YES/NO
Avoids loud sounds, textures or noises YES/NO	Experiences of back/ neck pain YES/NO	Frequent diarrhoea/constipation YES/NO

Please elaborate on anything above if needed: _____

_____

_____

How your Child uses their Body

How your child's body and brain communicate; please circle YES or NO

Doesn't like to OR can't sit still for short periods of time: YES/NO	Avoids activities with movement or balance: YES/NO
Difficulty learning to ride a bike: YES/NO	Loves swings and spinning: YES/NO
Hesitant of stairs: YES/NO	Difficulty learning to skip: YES/NO
Frequently drops things: YES/NO	Walks on tip toes frequently: YES/NO
Does not like closing eyes for tasks: YES/NO	Sleeps with the light on: YES/NO
Frequently bumps into things: YES/NO	Avoids/dislikes chewy foods: YES/NO
Seems weak/tired a lot: YES/NO	Difficult with buttons/laces: YES/NO
Breaks items easily: YES/NO	Poor posture or slumps in chairs: YES/NO

Please circle the things your child has frequent difficulty with;

Reading	Spelling	Handwriting	Maths
Organisation	Memory	Concentration	Following Directions
Sports	Emotional Regulation	Sleeping	Friendships

Thank you for your time and detailed responses

Legal Stuff

Privacy Policy Statement:
In accordance with the new Privacy Act, all information relative to your case is held in total confidence. However, your consent is necessary to allow us to exchange information between chiropractors within this clinic. Also, when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

Policies on Fees, Guarantees, Disclosed Information and Research:

1. I understand that appointments not attended or cancelled with less than 24hours notice may incur a charge and that payment is required at the time of consultation. This fee is $50 for cancellations with less that 24hours notice and a full scheduled fee for appointments not cancelled and not attended.
2. I appreciate that positive results of any treatment that I receive at Health Matters is not guaranteed. I understand that the team at Health Matters does not aim to treat my symptoms, but address any dysfunction identified.
3. I have disclosed any past or current illness, surgery, previous trauma, medications, drug use and any known health risks in the questionnaire provided, and agree to provide any related new information during the period of care at this clinic, or by practitioners who have assessed or treated me at this clinic.
4. Information gained from the initial assessment and follow up sessions may be used for internal research purposes or publishable research to help establish improved assessment and treatment protocols and promote a greater understanding of this field of healthcare in the scientific community. No personal details (name, contact details, etc.) will be disclosed in any published material.

The Risks & Current Research about Chiropractic Care for Children

5. As with any health care examination and treatment there is a risk of the condition changing. Current (2009) research from the International Chiropractic Pediatric Association demonstrated chiropractic care is very safe and effective for children. The research of 5438 chiropractic visits, 577 children, indicated only two children (<1%) experience minor discomfort after adjustments, which readily resolved with continued chiropractic care. The research showed both parents and doctors indicated a high rate of improvement with respect to the children's presenting complaints. Parents also reported better sleeping patterns, improvements in behaviour and, improved immune system function while under chiropractic care.
6. Chiropractic and other techniques used at this clinic are well recognised as being extremely safe health care interventions for people of all ages. However, as with all health care disciplines, there is a risk of complications. This may include soreness; muscle, bone or joint injury; worsening of symptoms; vision, hearing or balance problems; stroke (current statistics e.g. between 1 in 2million to 1 in 5.85 million – Haldeman, et al. Spine vol 24-8 1999) or side effects caused by the use of nutritional or herbal products that may be recommended. If I have any concerns, I will discuss them prior to treatment or during the course of a treatment programme if any new concerns arise.
7. I understand that the above mentioned risks of treatment exist. However, I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care.
8. I hereby acknowledge that I have carefully read all of the above information and that I understand and agree to each point that is made.

Carer's Name: _____ Child's Name:_____

Signature: _____ Date: _____