NEW CLIENT - CHILD 7 MONTHS - 12 YEARS

coast to country CHIROPRACTIC

WELCOME TO COAST TO COUNTRY CHIROPRACTIC AND THANK YOU FOR CHOOSING US

CHILD'S SURNAME: CHILD'S FIRST NAME(S):

DATE OF BIRTH SEX: O **MALE** O **FEMALE**

PARENT'S/GUARDIAN'S NAMES:

POSTAL ADDRESS

PARENT'S/GUARDIAN'S CONTACT NUMBERS: (HOME) (MOBILE) (WORK)

PARENT'S/GUARDIAN'S EMAIL ADDRESS*

CONCESSION CARD NUMBER: EXP DATE:

PRIVATE HEALTH FUND: ELIGIBLE TO CLAIM CHIROPRACTIC O **YES** O **NO** REMEDIAL MASSAGE O **YES** O **NO**

MEDICAL DOCTOR'S NAME: LOCATION OF DOCTOR:

HOW DID YOU FIND OUR CLINIC? O BILLBOARD O SIGNAGE O CAR SIGNAGE O GATTON STAR O OTHER NEWSPAPER O YELLOW PAGES O INTERNET/WEBSITE O FACEBOOK O FAMILY/FRIEND O EVENTS/EXPO O RADIO O PERSONAL TRAINING O OTHER (PLEASE DESCRIBE):

IF WE WERE RECOMMENDED, PLEASE STATE WHO RECOMMENDED US: MAY WE USE YOUR NAME TO THANK THEM? O **YES** O **NO**

NAME OF PERSON:

HAS YOUR BABY EVER RECEIVED CHIROPRACTIC CARE BEFORE? O **YES** O **NO**

HAVE YOU EVER RECEIVED CHIROPRACTIC CARE BEFORE? O **YES** O **NO**

IF YES, WHEN WAS YOUR LAST VISIT? _____ NAME OF CHIROPRACTOR: _____

REASON FOR TODAY'S VISIT:

Answering the following questions will help us to review important aspects of your child's health history and lifestyle. This will enable us to best determine how we may help your child to achieve better levels of health and well being.

NUTRITION

WAS / DOES / IS YOUR CHILD:

- BREAST FED? O **YES** O **NO** IF YES HOW LONG FOR?: _____
- FORMULA FED? O **YES** O **NO** IF YES TYPE OF FORMULA: _____
- HAVE ANY DIGESTIVE DISTURBANCES? O **YES** O **NO** IF YES DESCRIBE: _____
- HAVE ANY FOOD ALLERGIES? O **YES** O **NO** IF YES DESCRIBE: _____
- HAVE ANY PERSISTENT OR INTERMITTENT SKIN RASHES? O **YES** O **NO** IF YES DESCRIBE: _____
- RECEIVING ANY VITAMIN SUPPLEMENTS? O **YES** O **NO** IF YES DESCRIBE: _____
- EATING SOLID FOOD? O **YES** O **NO** IF YES DESCRIBE: _____

WHAT DOES YOUR CHILD USUALLY EAT FOR:

- BREAKFAST? _____
- LUNCH? _____
- DINNER? _____
- SNACKS?

WHAT IS YOUR CHILD'S FAVOURITE FOOD?

HOW MUCH COW'S MILK DOES YOUR CHILD DRINK EACH DAY?

HOW MUCH WATER DOES YOUR CHILD DRINK EACH DAY?

*COAST TO COUNTRY CAN ISSUE APPOINTMENT REMINDERS AS WELL AS INFORMATION AND OFFERS VIA EMAIL, IF YOU DO NOT WISH TO RECEIVE THESE EMAILS FROM US PLEASE LEAVE THIS FIELD BLANK. WE RESPECT YOUR PRIVACY AND DO NOT RELEASE ANY CLIENT INFORMATION TO THIRD PARTIES WITHOUT YOUR CONSENT.

Please Turn Over

CONT…

WHAT TYPE OF FAST FOODS DOES YOUR CHILD LIKE TO EAT?

HOW MANY SOFT DRINKS DOES YOUR CHILD DRINK EACH DAY?

DOES YOUR CHILD HAVE ANY FEEDING DIFFICULTIES? O **YES** O **NO** IF YES PLEASE DESCRIBE:

HEALTH HISTORY

IS / DOES / HAS YOUR CHILD:	**IF YOU ANSWER YES TO ANY OF THE FOLLOWING PLEASE DESCRIBE**
- ALLERGIC TO ANYTHING?	O **YES** O **NO** HOW LONG FOR?: _____
- HAD COLIC?	O **YES** O **NO** TYPE OF FORMULA: _____
- HAD ANY UPPER RESPIRATORY INFECTIONS?	O **YES** O **NO**
- HAD ASTHMA?	O **YES** O **NO**
- EVER COMPLAIN OF BACK OR NECK PAIN?	O **YES** O **NO**
- EVER COMPLAIN OF PAIN IN THE ARMS OR LEGS?	O **YES** O **NO**
- EVER COMPLAIN OF HEADACHES?	O **YES** O **NO**
- EVER HAD OR HAVE PROBLEMS WITH BED WETTING?	O **YES** O **NO**
- BEEN VACCINATED?	O **YES** O **NO**
- PRESENTLY RECEIVING ANY MEDICATIONS?	O **YES** O **NO**
- HAD ANY EARACHES?	O **YES** O **NO** AT WHAT AGE DID THE FIRST OCCUR: _____
- DO THESE EARACHES TEND TO OCCUR IN THE SAME EAR?	O **YES** O **NO** RIGHT / LEFT / BOTH?

PLEASE LIST ANY OTHER ILLNESSES WHICH HAVE BEEN A CONCERN FOR YOUR CHILD:

PLEASE LIST ANY SURGERIES YOUR CHILD HAS HAD:

HAS YOUR CHILD:	**IF YES PLEASE DESCRIBE:**
- EVER FALLEN DOWN STAIRS?	O **YES** O **NO**
- BEEN IN A CAR ACCIDENT OR NEAR MISS?	O **YES** O **NO**
- HAD A FRACTURE OR DISLOCATION?	O **YES** O **NO**
- HAD ANY FALLS, INJURIES OR TRAUMA?	O **YES** O **NO**

DO YOU HAVE ANY OTHER CONCERNS YOU WISH TO DISCUSS? O **YES** O **NO**

YOUR HEALTH OBJECTIVES

People consult this office with one or more of the following health objectives. Please tick those which apply to you and/or your child.

- O **CORRECTION OF THE UNDERLYING CAUSES OF MY CHILD'S SYMPTOMS AND HEALTH PROBLEMS**
- O **PREVENTION OF THE DEVELOPMENT OF SYMPTOMS, HEALTH PROBLEMS AND DEGENERATION**
- O **ACHIEVEMENT OF AN OPTIMAL LEVEL OF HEALTH AND WELL BEING FOR MY CHILD**
- O **OPTIMAL HEALTH AND WELL BEING FOR MY WHOLE FAMILY**

I acknowledge that the above information is correct and I have not knowingly withheld any information that is relevant to my baby's health and treatment.

PARENT'S /GUARDIAN'S SIGNATURE		**DATE**	