NEW CLIENT - BABY 0 - 6 MONTHS

coast to country
CHIROPRACTIC

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

BABY'S SURNAME: BABY'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? ________________________ CHIROPRACTOR NAME: ________________________________

BRIEF MEDICAL HISTORY

HOW LONG WAS THE LABOUR - FROM THE FIRST REGULAR CONTRACTION TO THE BIRTH? _______________ HOURS

HOW LONG WAS THE 2ND STAGE (PUSHING STAGE) OF THE LABOUR? _______________ HOURS

BIRTH WEIGHT ________________KGS / LBS BIRTH LENGTH: _______________ CMS/ INS

THE BIRTH OF YOUR CHILD CAN GIVE VITAL CLUES TO POTENTIAL HEALTH PROBLEMS. PLEASE TICK ALL APPLICABLE TO THE BIRTH:

O HOSPITAL BIRTH	O HOME BIRTH	O MIDWIFE ASSISTED
O VAGINAL BIRTH	O PLANNED CAESAREAN	O EMERGENCY CAESAREAN
O INDUCED	O FORCEPS DELIVERY	O VACUUM EXTRACTION
O FOETAL DISTRESS	O MECONIUM STAINING	O ANAESTHESIA ADMINISTERED
O HEAD PRESENTATION	O FACE PRESENTATION	O BREECH PRESENTATION

*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

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

IS YOUR BABY TAKING ANY PRESCRIBED MEDICATIONS ○ **YES** ○ **NO**
HAS YOUR BABY HAD ANY VACCINATIONS ○ **YES** ○ **NO**

DOES YOUR BABY:

- GO TO SLEEP EASILY ○ **YES** ○ **NO**
- HAVE A PREFERRED SLEEPING POSITION? ○ **YES** ○ **NO** IF YES PLEASE DESCRIBE: ______________________
- CRY IF YOU CHANGE SLEEPING POSITION? ○ **YES** ○ **NO**

DOES / IS YOUR BABY: *(if you answer yes to any of these questions then please add detail)*

- HAVE ANY FEEDING DIFFICULTIES? ○ **YES** ○ **NO**
- BEING BREASTFED? ○ **YES** ○ **NO**
- HAVE A ONE-SIDED BREAST FEEDING PREFERENCE? ○ **YES** ○ **NO** IF YES ○ LEFT ○ RIGHT BREAST
- FORMULA FED? ○ **YES** ○ **NO** TYPE OF FORMULA: ______________________________
- FREQUENTLY SPIT UP AFTER FEEDING? ○ **YES** ○ **NO**
- CRY A LOT? ○ **YES** ○ **NO** IF YES HOW MANY HOURS? _____________________
- PASS A LOT OF INTESTINAL GAS? ○ **YES** ○ **NO**
- HAVE A PREFERRED HEAD POSITION? ○ **YES** ○ **NO**
- FREQUENTLY ARCH HIS/HER HEAD AND NECK BACKWARDS? ○ **YES** ○ **NO**
- CRY OR BECOME IRRITABLE DURING A DIAPER CHANGE? ○ **YES** ○ **NO**

HAS YOUR BABY EVER: *(if you answer yes to any of these questions then please add detail)*

- HAD A FEVER? ○ **YES** ○ **NO**
- HAD ANY FALLS? ○ **YES** ○ **NO**
- BEEN IN A CAR ACCIDENT OR NEAR MISS? ○ **YES** ○ **NO**
- HAD ANY OTHER TRAUMA? ○ **YES** ○ **NO**

DO YOU HAVE ANY OTHER CONCERNS YOU WISH TO DISCUSS? ○ **YES** ○ **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.

○ CORRECTION OF THE UNDERLYING CAUSES OF MY BABY'S SYMPTOMS AND HEALTH PROBLEMS

○ PREVENTION OF THE DEVELOPMENT OF SYMPTOMS, HEALTH PROBLEMS AND DEGENERATION

○ ACHIEVEMENT OF AN OPTIMAL LEVEL OF HEALTH AND WELL BEING FOR MY CHILD

○ 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**	