Dear Parent or Caregiver – Thank you for making the important decision to have your child checked by a Doctor of Chiropractic.

Please answer the following questions as best you can and sign the consent at the end of this form. Some of the following questions may seem irrelevant to your child's case. However, they assist us in delivering the safest and best possible care, and many are required by law. All information given is **private and confidential.**

Koru Clinic Child Case History - Personal Details

Child's Full Name: ____________________

Male ☐ Female ☐ Date of Birth: ____________ Age: ________

Parent or Caregiver's Name: ____________________

Address: ____________________

Telephone: Home- ____________ Work- ____________ Mobile- ____________

Medical Doctor: ____________________

How did you hear about our office (e.g. referral from GP, friend, phonebook etc):

____

Has your child ever had Chiropractic Care before: Yes ☐ No ☐

Current Health Conditions

Reason for this appointment (e.g. wellness care, back pain, colic, asthma, headaches, posture etc):

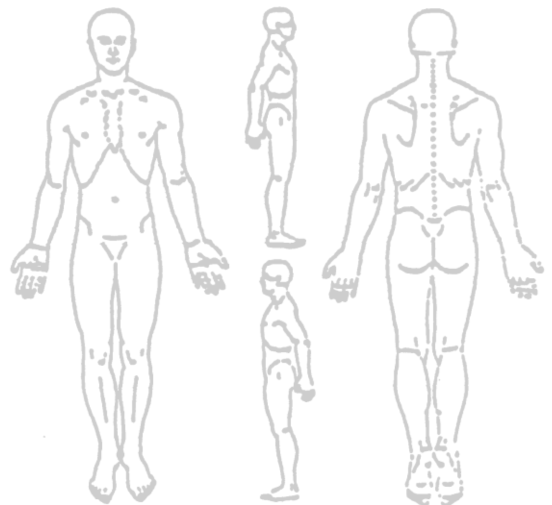
____

When did this condition begin: ____________________

How did this condition begin (e.g. birth injury, accident – dropped, fall, slowly developed) ____________

____

Please outline any areas of pain, discomfort, or concern on the diagrams, and label with the letter that best describes it:



S = Sharp / Stabbing
D = Dull / Achy
P = Pins & Needles
N = Numbness
B = Burning
O = Other

Other practitioners seen for this condition (e.g. GP, physio etc):

____

____

Does anything make it better ____

Does anything make it worse ____

Current medications (list names and dosage if possible):

____

Has your child previously been on any medications? Yes ☐ No ☐

Has your child been treated for any other health condition in the last year? Yes ☐ No ☐

If Yes, please explain:

____

Tick Any Of The Following Your Child Has Had

NEURO- MUSCULO -SKELETAL

- ☐ Clicky hips
- ☐ Inability to suckle
- ☐ Difficulty turning head to one side (eg. feeds only off one breast)
- ☐ Headaches
- ☐ Migraines
- ☐ Weakness
- ☐ Paralysis or Reluctance to move a limb
- ☐ Walking Problems
- ☐ Poor Balance / Co-ordination
- ☐ Dizziness
- ☐ Fainting
- ☐ Anxiety
- ☐ Low-Back Pain
- ☐ Neck Pain
- ☐ Pain between Shoulders
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Stiffness
- ☐ Numbness, Tingling, Burning, or Pins & Needles
- ☐ Confusion
- ☐ Depression
- ☐ Convulsions

CARDIO - RESPIRATORY

- ☐ Heart Problems
- ☐ Coughing
- ☐ Gasping, Wheezing, Choking or Chest Pain
- ☐ Lung Problems

GASTRO-INTESTINAL

- ☐ Poor Appetite / Feeding
- ☐ Poor Weight Gain
- ☐ Excessive Appetite or Weight Gain
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Regurgitation
- ☐ Liver Problems
- ☐ Kidney Problems
- ☐ Bowel Problems (e.g. bleeding, constipation, gas, diarrhoea, cramps)
- ☐ Hernia

GENITO-URINARY

- ☐ Bladder Problems (eg. Bedwetting, frequency)
- ☐ Painful Urination
- ☐ Discoloured Urine
- ☐ Early Onset Puberty

EARS/EYES/NOSE/THROAT/

- ☐ Allergies
- ☐ Ear Ache / Infection
- ☐ Nasal Congestion/Discharge
- ☐ Sore Throat
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Hearing Difficulties

GENERAL

- ☐ Congenital Abnormality
- ☐ Colic
- ☐ Stress
- ☐ Poor sleep
- ☐ Fever

☐ Other ____________________

Has your child ever had X-rays or other Imaging ?

No ☐ Yes ☐

Date:____________________

Past Health History

Please tick if your child has, or has had, any of the following conditions:

Childhood Diseases: Measles ☐ Mumps ☐ Chicken Pox ☐ Whooping Cough ☐

Other: Diabetes ☐ Cancer ☐ Genetic Disorder ☐ Clotting Disorder ☐ Epilepsy ☐

Other Illness not already specified ☐ ____

Surgery / Operations (e.g. Appendix, Tonsil or Adenoid removal, Grommets etc):

____

Significant accidents, falls, or sports injuries (include approximate date):

____

____

Hospitalisation (other than above):____

Vaccinations / Shots your child may have had: MMR ☐ DPT ☐ Flu ☐ Other ☐ ______________

Please describe any changes these may have made to your child's state, irritability, or function:

____

Family history of major illnesses e.g. Diabetes (mother):___________________________________

____

Birth Process and Status

Birth: Natural ☐ Induced ☐ Hospital ☐ Home Birth ☐ Birthing centre ☐
Vaginal ☐ Caesarean Section ☐ Forceps ☐ Vacuum Extraction ☐
Premature ☐ Overdue ☐

Birth Weight _____________ Birth Head Shape _______________________

Position at birth: Vertex (normal) ☐ Transverse lie ☐ Breech ☐

Was there any Sedation/Anaesthesia ☐ Type ______________________________

Birth Trauma (eg. fractured clavicle, brachial plexus injury) ____________________________________

Maternal Illness or Problems during pregnancy (eg. High BP, Malnutrition, Back Pain) _____________

____

Maternal Exposure to toxins: Cigarettes ☐ Alcohol ☐ Drugs ☐ Medications ☐

Number of previous pregnancies and/or births _______

Child's Development and Lifestyle:

Childhood Developmental Milestones obtained:

Respond to sound ☐ Follow visual stimulus ☐ Hold head up ☐ Sit alone ☐ Crawl ☐ Stand alone ☐
Cruise (walk holding furniture) ☐ Walk alone ☐ First Word ☐ Read ☐ Write ☐

Were there any major delays in reaching these milestones (please explain)? ________________________
____

Does your child mainly sleep on their: Side ☐ Stomach ☐ Back ☐

Hours of sleep (per 24hrs) __________ Quality: Good ☐ Fair ☐ Poor ☐

Sports / Hobbies and Activities: ____

Chiropractic acknowledges that the body has an innate ability to heal. Chiropractors strive to assist the natural healing response by correcting ***Vertebral Subluxations****. Vertebral Subluxations are areas of the spine that are not functioning correctly. Slight misalignments of the vertebrae (bones of the spine) may cause nerve interference by placing pressure on the spinal cord and nerves as they pass through the spine. The Nerve System is vitally important to our wellbeing because it controls and co-ordinates all functions of the body. If the flow of nerve information around the body is disrupted, the healing response is compromised, and many health problems can arise.*

Parent or Guardian's Signature – consent for care: _____________________ Date: _____________

Thank you for filling out this important information.

Enjoy your visit and the many benefits of Chiropractic Care!