Child Medical History Form

Welcome to Vibrant Life

Our mission is to educate and adjust as many families as possible towards optimal health through functional neurology and natural health care. Misalignments of the body and nervous system are called subluxations and prevent the body from having optimal health. Please fill out this questionnaire as carefully as you can so that we can begin to assess your child's current level of health.

Personal Details:

Who is completing this form? _____ Date: _____

Relationship to child: _____

About the Child:

Surname: _____ First Names: _____

D.O.B: _____ Age: _____ Gender: _____

Address: _____ Post Code: _____

Email: _____

Home Phone: _____ Others Phone: _____

Mother Name: _____ Age: _____ Father Name: _____ Age: _____

Siblings Name & Ages: _____

Current Height: _____ Current Weight: _____

Birth Length: _____ Birth Weight: _____ Birth Head Circumference: _____

Current Health:

How would you rate your child's current level of health? _____

How would you rate your family's current level of health? _____

Does your child have any current health concerns or symptoms? Please describe what, where, when, how long?

Does you child currently take any medication or supplements? _____

What and what for? _____

Has your child had this or a similar condition before? _____

If so when? _____

Medical History:

GP: _____ Surgery: _____ Date: _____

Any Major illness or disease? _____ What and When? _____

Has your child been hospitalised? _____ Why and When? _____

Has your child been prescribed drugs? _____ Please detail: _____

Has he /she ever had any operations? _____ Please detail: _____

Birth:

Were there any complications with baby's or mother's health during pregnancy? Please detail:

Were there any complications during delivery? _____ Please detail: _____

Where was your child born? _____ Was your child born early or late? No of weeks: _____

Were there any complications with delivery? _____ Please detail: _____

Were any drugs used during labour? _____ Please detail: _____

Was the birth: _____

Feeding History:

Was / is your child: _____ How long for? _____ Name of formula? _____

Accidents & Injuries: (Most babies and children have accidents & injuries)

Has your child ever been dropped or fallen from a chair, bed or table? When? Please detail:

Has he/she had any other accidents ie. Car or sports injuries? Please detail:

Has your child ever had any broken bones? Please detail:

Lifestyle:

Does your child have any fears / phobias? _____

Does your child have any allergies? _____

Does he / she have reactions to any food? _____

Do any family members have allergies or food reactions? _____

Does your child take part in any regular sports or activities? _____

Is he / she a member of any groups or teams? _____

Consent to Examination: (To be signed by the child's parent or guardian **before the Chiropractic Examination)**

The techniques used to examine your child may include palpation (using the hands to feel the position and movement of joints), postural assessment and neurological assessment (reflex and muscle strength testing). Should x-rays be required the chiropractor will discuss this with you. Your child should be dressed in light clothing i.e. shorts and t-shirt. Babies should have on only a (clean) nappy.

I , _____ have read and understand the information above and have filled in this form to the best of my knowledge. I request a chiropractic examination for my child.

Signature: _____ Relationship to child: _____

Name: _____ Date: _____

Consent to Treatment: (To be signed by the child's parent or guardian **after the Report of Findings)**

I hereby request and consent to the performance of chiropractic procedures on my child by the Doctor of Chiropractic (DC) named below, and or any other duly qualified DC working in this County Chiropractic clinic. I acknowledge that I have discussed the nature and purpose of chiropractic adjustments and I understand that results cannot be guaranteed.

It has been explained to me in plain English and I understand that, as in the practice of medicine and healing arts Chiropractic care can carry slight risks. I do not expect the DC to be able to explain or anticipate all of the possible risks or complications associated with my child's particular case. Therefore it is my desire to rely on the DC to exercise judgment during the course of my child's care and to act in the best interests of my child at all times.

I confirm that I have read and understood the above statement and have been given the opportunity to ask questions about it. It is my intention that this consent to chiropractic care covers the entire course of treatment for my child's present condition, any future conditions and for Well Baby / Well Child check ups

Child's Name: _____

Parent / Guardian: _____ Signature: _____ Date: _____

Chiropractor name: _____ Signature: _____ Date: _____