healthspace

PEDIATRIC : 1-12 Years old

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WELCOME TO HEALTHSPACE AND THANK YOU FOR CHOOSING US!

CHILD'S NAME M / F D.O.B.

ADDRESS SUBURB & POSTCODE

GUARDIAN 1. NAME: RELATIONSHIP

GUARDIAN 2. NAME: RELATIONSHIP

Guardian Phone: HOME MOBILE WORK

Guardian Email Address:

NAMES & AGES OF SIBLINGS:

PRIVATE HEALTH FUND: MEDICARE NUMBER:

GENERAL PRACTITIONER:

GP ADDRESS & PHONE NUMBER:

Who can we thank for referring you to Health Space?

GENERAL HEALTH HISTORY—If the mother or child has had any of the following, please circle Yes or No.

PRENATAL (CONCEPTION TO BIRTH)
While pregnant with your child, did the child's mother:

Have a sedentary lifestyle	Yes	No
Smoke or drink alcohol	Yes	No
Have a poor diet	Yes	No
Have any falls or injuries	Yes	No
Suffer from high blood pressure	Yes	No
Suffer any other illness	Yes	No
Take any prescribed medications	Yes	No
Have Proteinuria	Yes	No
Have X-rays/ultrasounds	Yes	No

Duration of pregnancy in weeks .....

Age of mother at time of birth .....

Any previous miscarriages/stillbirths? .....

PERINATAL (BIRTH)
During the birth did any of the following occur?

Premature delivery	Yes	No
Long or difficult delivery	Yes	No
Forceps or Vacuum extraction	Yes	No
Caesarean section	Yes	No
Breach or other unusual presentations	Yes	No
Use of drugs during labour	Yes	No
Induced labour	Yes	No

Length of time in labour—Stage 1:..... Stage 2:.....

APGAR score at 1min: ..... 5 mins:.....

Weight at birth ..... Length at birth .....

Head circumference .....

NEONATAL
Immediately after the birth/during infancy, did any of the following occur?

Need for the child to be respirated	Yes	No
Need for the child to be kept in a humidicrib	Yes	No
Administered any medications	Yes	No
Other significant accidents	Yes	No
Difficulty feeding / latching / sucking	Yes	No
Head banging or rocking	Yes	No
Recurrent childhood sicknesses	Yes	No
Surgery	Yes	No
Failure to grow / gain weight	Yes	No
Show any unusual movements	Yes	No
Has disrupted sleep patterns	Yes	No
Had speech or language difficulties	Yes	No

○ Breast-fed ○ Bottle Fed—Formula Type: .....

Any of the following childhood illnesses:

○ Measles ○ Rubella ○ Mumps ○ Chicken Pox

Any allergies / sensitivities .....

OTHER
Please circle any other relevant conditions below:

Teeth	Eyes	Hearing	Coughs/Colds
Headache	Backache	Gas	Bloating
Constipation	Diarrhoea	Hard Stools	Loose Stools
Poor circulation	Hot/cold hands or feet	Reflux	Palpitations
Difficulty urinating	Frequent urinating	Skin rashes/conditions	
Nappy rash	Flaking Scalp		

VACCINES & IMMUNISATIONS:
Has your child received all the recommended immunisations? ○ Yes ○ No ○ Some

Vaccine names: Age Given:

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MEDICAL HISTORY—Has your child ever experienced any of the following?

More than 2 ear infections	Yes	No
Hearing difficulties	Yes	No
Visual difficulties	Yes	No
Movement problems (special shoes/braces)	Yes	No
Failure to thrive	Yes	No
Poisoning / overdose	Yes	No
Fainting / unconscious spells	Yes	No
Convulsions / seizures / epilepsy	Yes	No
Bed wetting beyond 5 years old	Yes	No
Sleeping difficulties	Yes	No
Poor growth or excessive weight gain	Yes	No
Reactions to immunisations	Yes	No
Headaches	Yes	No
Any night pain	Yes	No
Production of unusual odours	Yes	No
Difficulty swallowing	Yes	No
Loss of previously obtained skills (speech/motor)	Yes	No
Toe walking	Yes	No
Run / walk more awkwardly than kids their age	Yes	No
Unusual movements / tics	Yes	No

Has your child ever been diagnosed with a developmental disorder?
YES / NO

.....

Has your child ever received any special education or counselling?
YES / NO

.....

Have you consulted other professionals regarding your child before?
YES / NO

.....

Is your child currently on any medications or taken any in the past?
YES / NO If yes, please list what and why?

.....

.....

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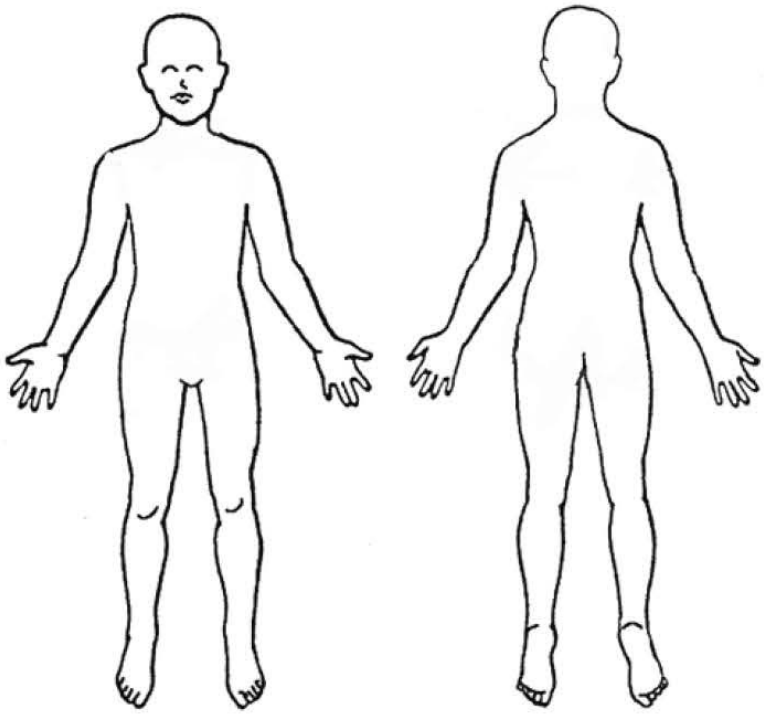
Please mark on the diagram below where your child is experiencing or showing signs of discomfort:



DEVELOPMENT

< 6mths / 6-12 mths / 18-24 mths / 24-36 mths / 36-48 mths / >48 mths

Approximately how old was your child when they first:

Had more than 2 ear infections .....

Crawled .....

Stood unsupported .....

Walked with assistance .....

Walked without assistance .....

Showed hand preference .....

Toilet trained (bowel) .....

Toilet trained (bladder) .....

Began to use words .....

Began to talk in sentences .....

Began to vocalise (babble) .....

Which hand does your child prefer .....

SOCIAL SKILLS

Does your child:

Tend to be the boss or the follower	Boss		Follower	Have temper tantrums or lose their temper easily	Yes	No	Sometimes
Avoid affection	Yes	No	Sometimes	Appear to have their feelings hurt easily	Yes	No	Sometimes
Play and take turns with other kids readily	Yes	No	Sometimes	Avoid eye contact with people	Yes	No	Sometimes
Appear to be in a world of their own/daydream frequently	Yes	No	Sometimes	Mood change easily	Yes	No	Sometimes
Exhibit repetitive movements when stressed or excited	Yes	No	Sometimes	Get frustrated easily	Yes	No	Sometimes
Appear frightened / anxious in new situations	Yes	No	Sometimes	Get distracted easily	Yes	No	Sometimes
Have verbal / physical fights with adults / children / parents	Yes	No	Sometimes	Frequently stand aside of a group of kids their age	Yes	No	Sometimes

How long can your child sit while watching a fascinating activity or be read to? .....

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In order for the Chiropractor to make a determination on the suitability of my child's/guardian's case for care, I acknowledge and understand that a thorough history, evaluation and examination must be completed. I do hereby request and consent to the performance of such an evaluation and examination by the Chiropractor I have booked my child/guardian in with or any party authorised to do so by that person.

I understand I that I am encouraged to discuss with the Doctor of Chiropractic, or with any party authorised to do so by that Chiropractor, about the nature and purpose of the examination process before it begins. I understand that there may be remotely associated risks with treatment, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination or treatment at any time. I also understand that by signing this form and giving verbal consent before the treatment that the chiropractor continues to be obligated for best practices delivered in the child's interests at all times.

Parent/Guardian Signature ..... Date ...../...../.....

Thank you for completing this form. If you have any other information, questions or concerns to add below, please add notes which can then be discussed with the doctor. We are here to serve you and are happy to explain things as much as possible so you feel comfortable that your child is receiving the best and most up to date natural health care available.

Your information is private and confidential, however we may need to correspond with various third parties, including your GP, specialist or insurance company.

Health Space provides an appointment reminder service by SMS and may also communicate with you by SMS and email from time to time.

All clients are automatically enrolled in this service. If you do not wish to have this service please indicate below:

○ Please do not send me appointment reminders by SMS.

○ Please do not send me Health Space updates by email.