

Point Cook Chiropractic Health & Wellness Centre  
**Child Intake Form 0 - 2 years**

Please Print Clearly and Complete All Information

Date: \_\_\_\_\_

Name: **Mast / Miss** \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_ P/Code: \_\_\_\_\_

Phone: (H): \_\_\_\_\_ (M): \_\_\_\_\_ Email: \_\_\_\_\_

Who can we thank for referring you to our office?  
\_\_\_\_\_

Has the child had Chiropractic Care before? Y / N (circle). If yes, name of chiropractor and date of last visit:  
\_\_\_\_\_

Have the Parent(s) had Chiropractic Care before? Y / N (circle). If yes, name of chiropractor and date of last visit:  
\_\_\_\_\_

Primary reason for consulting our office:  
\_\_\_\_\_

When did it start? \_\_\_\_\_ Has he/she had this before? If so, when: \_\_\_\_\_

Any other associated warning signs, symptoms or complaints?: \_\_\_\_\_

Have any health professionals been consulted for this condition? Yes / No (please circle)

If **Yes**, please list their profession and their diagnosis below:

\_\_\_\_\_ Diagnosis: \_\_\_\_\_

Has it helped? Yes / No

**Birth:**

Hospital Birth? Yes No Breech or unusual presentation? Yes No

Premature delivery? Yes No Was labour induced? Yes No

Long or Difficult birth? Yes No Caesarian? Yes No

How long was labour? \_\_\_\_\_

Was the mother medicated during the birth process? \_\_\_\_\_

Was it gas or epidural? \_\_\_\_\_

Weight at birth? \_\_\_\_\_

**General Health Questions:**

What medical conditions has the child had or currently suffering from?  
\_\_\_\_\_

Has the child had any previous surgery? \_\_\_\_\_

Is he/she taking any medications? Yes / No (please list)  
\_\_\_\_\_

Does the child has any ongoing health problems? Yes / No

Did he/she has any abnormal bleeding from any body part? Yes / No

Does the child has any unusual lumps or swellings? Yes / No

Has anyone in your family (incl Aunts, Uncles, Grandparents) had any of the following?

Heart disease \_\_\_\_\_  Arthritis \_\_\_\_\_

Thyroid Disease(Goitre ) \_\_\_\_\_  Diabetes \_\_\_\_\_

Cancer

**SYSTEMS REVIEW HISTORY**

Years of uncorrected problems may lead to many different acute or chronic symptoms. These provide clues to the cause of the child's condition. Please **tick the appropriate box** if he/she has had or is suffering from the following health conditions. Leave blank any that do not apply.

**O = Occasionally, F = Frequently, C = Constantly**

O	F	C		O	F	C		O	F	C		O	F	C	
			<b>Head</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath				<b>Genito-Urinary System</b>				<b>General Symptoms</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tightness around Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Racing Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty starting urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chills
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thumping Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ears					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leakage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Buzzing in Ears				<b>Stomach</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Fatigue
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching/Excessive Wind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy Loss
			<b>Neck</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fevers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bloatedness					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Sleep
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soreness/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clicking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Sweating
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors
			<b>Shoulders/Arms/Fingers</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pins & Needles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restricted Movement				<b>Low Back/Legs/Feet</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pins & Needles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold/Hot Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restricted Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
			<b>Chest</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold/Hot Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain around Ribs												

**Health Status:** Using the 0 – 10 scale below, 10 being Excellent health, please circle what you believe is your child's current state of health.

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10  
 Very Poor      Poor      Average      Good      Excellent

**What steps do you think you could take to improve your child's health?** (eg. More rest, eating better, etc.) \_\_\_\_\_

**Wellness Commitment:** At **Point Cook Chiropractic** we are dedicated toward achieving the goal of total lasting health for our members. To better help your child achieve this, we need to understand your commitment toward being healthy. We *do not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10% — 20% — 30% — 40% — 50% — 60% — 70% — 80% — 90% — 100%

Please note that any and all information, written or otherwise, that you provide is strictly confidential and is so treated by the entire staff. No information or records will be released to any person (health practitioner or otherwise), health fund, or insurance company without the written permission of the patient.

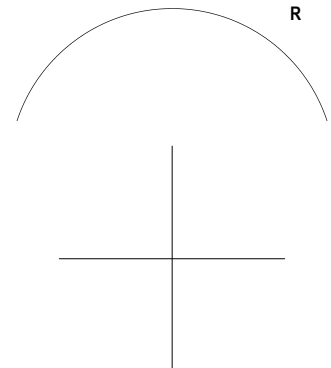
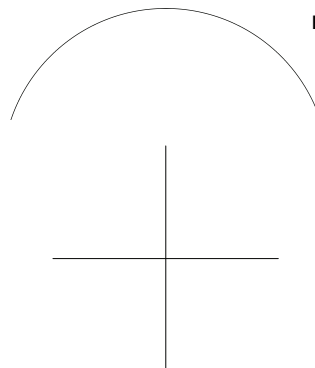
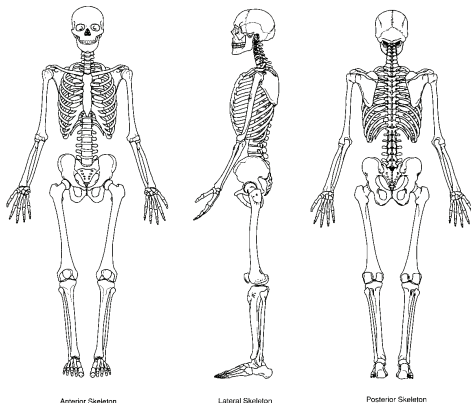
**I believe the information above is correct to the best of my knowledge.**

Parent's Signature: \_\_\_\_\_

Date:    /    /

**Doctor's Notes**

**ROM:**



BWS:      L: \_\_\_\_\_ kg      R: \_\_\_\_\_ kg

Handedness:    L    R

Cx

Lx