

Welcome to think.

think. Kohi Chiropractic

To help us know more about your family and their health status and needs please complete the following form.
(Please talk to reception if you have any queries)

287 Kapa Road
Kohimarama 1071
ph 09 521 2045
email think.kohichiro@gmail.com

Todler/Child (3-6 years) New Patient Information

Today's Date _____

Child's name: _____ Nickname: _____

Reason for visit: _____

Sex: M/F Date of Birth: _____ Age: _____

Home Phone Number: _____ Email: _____

Address: _____

Family Information

Mother/Father name: _____ Mother/Father name: _____

Mobile Phone: _____ Mobile Phone: _____

Work phone: _____ Work phone: _____

List ages of other children in family: _____

Predominant language used at home: _____

G.P./ Paediatrician: _____ Phone _____

How did you find out about us? _____

The healthy function of every cell, tissue & organ in our bodies is dependent upon the integrity of the nervous system. This system consists of the brain, spinal cord and spinal nerves. Protecting these vital structures are the skull and the vertebrae of the spine. Chemical, Physical and Emotional stressors can upset the normal movement of the spinal bones interfering with the flow of information along the spinal nerves and throughout the nervous system. When this occurs it is called a vertebral subluxation. This questionnaire will help reveal the causes of vertebral subluxation which interfere with the optimal function of your nervous system and therefore impair your inborn health and well-being.

Consent for care

Being the parent or legal guardian of this child, I hereby authorize the attending chiropractor at Think Kohi Chiropractic to examine and administer care to my son/daughter named _____ as the examining chiropractor deems necessary.

I understand that I am personally responsible for payment of all fees charged by this office for such care.

Parents name: _____ Signature: _____ Date: _____

Has your child ever received chiropractic care? Yes No

If yes, who is your child's previous Doctor of Chiropractic?: _____

The date of last visit: _____

Other professionals seen for this condition: _____

What was the outcome? _____

Please tick the purpose for your child's visit: wellness maximizing normal growth and development

early detection of problems prevention crisis management other _____

Present Health Concerns _____

When did this problem begin? _____

Is this problem: occasional frequent constant intermittent

What makes this worse? _____

What makes this better? _____

Is the problem worse during a certain time of the day? Yes No

If Yes, when? _____

Does this interfere with the child's sleep? Yes No Eating? Yes No Daily routine? Yes No

Often seemingly unrelated symptoms can manifest as other health concerns.. Please tick if your child has had any of the following

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> headaches | <input type="checkbox"/> chest pressure | <input type="checkbox"/> weight loss | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> breast pain | <input type="checkbox"/> weight gain | <input type="checkbox"/> irritability | <input type="checkbox"/> frequent colds |
| <input type="checkbox"/> dental problems | <input type="checkbox"/> fatigue | <input type="checkbox"/> sinus congestion | <input type="checkbox"/> fevers |
| <input type="checkbox"/> depression | <input type="checkbox"/> sore throats | <input type="checkbox"/> heart palpitations | <input type="checkbox"/> loss of balance |
| <input type="checkbox"/> ear pain/infections | <input type="checkbox"/> numbness in feet | <input type="checkbox"/> loss of concentration | <input type="checkbox"/> asthma |
| <input type="checkbox"/> numbness | <input type="checkbox"/> fainting | <input type="checkbox"/> cold sweats | <input type="checkbox"/> weakness |
| <input type="checkbox"/> ears buzzing | <input type="checkbox"/> bronchitis | <input type="checkbox"/> heartburn | <input type="checkbox"/> poor coordination |
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> muscle cramps | <input type="checkbox"/> vision changes | <input type="checkbox"/> difficulty breathing |
| <input type="checkbox"/> upper back pain | <input type="checkbox"/> loss of memory | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> neck pain |
| <input type="checkbox"/> loss of smell | <input type="checkbox"/> allergies | <input type="checkbox"/> low back pain | <input type="checkbox"/> loss of taste |
| <input type="checkbox"/> constipation | <input type="checkbox"/> radiating pain | <input type="checkbox"/> light sensitivity | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> sleeping problems | <input type="checkbox"/> face flushed | <input type="checkbox"/> urinary problems | <input type="checkbox"/> numbness in leg(s) |
| <input type="checkbox"/> reduced mobility | <input type="checkbox"/> bloating/gas | <input type="checkbox"/> stiffness | |
| <input type="checkbox"/> Other: _____ | | | |

Birth History

What was the child's gestational age at birth? _____ weeks.

Birth weight _____ lbs _____ kg Birth length _____ inches

Was your child's birth: at home in a birthing centre hospital other

Was the birth considered: medical midwife

Duration of birth: _____ hours

Was child born: cephalic (head first) breech (feet first)

Were there any complications? Yes No If Yes, please explain _____

Assistances used during delivery: Forceps Vacuum extraction C-section Episiotomy

Was labour: induced spontaneous

Were medications or epidurals given to the mother during birth? Yes No

APGAR score: at Birth ____/10 After 5 minutes ____/10

Is there anything else we need to know about the birth? Yes No

If yes explain _____

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? Yes No

If no, please explain _____

At what age did the child: Respond to sound ____ Follow an object ____ Hold up head ____ Vocalize ____
Sit alone ____ Teethe ____ Crawl ____ Walk ____

Does your child sleep on their: front back side

Do you consider the child's sleeping pattern normal? Yes No

How many hours per day? _____ If no, please explain _____

Family Health History

Please note any health problems (ie: cancer, hereditary conditions, diabetes, heart disease) that are present in:

Mothers family _____

Fathers family _____

Siblings _____

Physical Stressors

Any traumas to the mother during pregnancy? (ie: falls, accidents, etc.) Yes No

If yes, please explain _____

Any evidence of birth trauma to the infant?

- respiratory depression cord around neck fast or excessively long birth
- bruising odd shaped head stuck in birth canal

Any falls from couches, beds, change tables, etc? Yes No

If yes, please explain _____

Any traumas resulting in bruises, cuts, stitches or fractures? Yes No

If yes, please explain _____

Any hospitalizations or surgeries? Yes No

If yes, please explain _____

Any sports played? _____

Is a school backpack used? Yes No Is it heavy or light?

Chemical Stressors

Was this child breast-fed? Yes No If yes, how long: _____

Formula introduced at what age: _____ Which formula? _____

Introduction of cow's milk at what age: _____ Began solid foods at what age: _____

Types of solid foods: _____

Food/Juice intolerance? Yes No Type: _____

Is your child on or have taken any medications? _____

During the mother's pregnancy

Did the mother smoke? Yes No How much? _____

Drink alcohol? Yes No How much? _____

Any illnesses during the pregnancy? Yes No If yes, describe: _____

Any supplements taken during pregnancy? Yes No If yes, describe: _____

Any drugs taken during pregnancy? Yes No _____

Any ultrasounds? Yes No How many: _____

Reasons for being done: _____

Any invasive procedures during pregnancy (ie amniocentesis, Chorionic villi sampling, etc.)? Yes No

If yes, please explain _____

Any pets at home? Yes No _____

Any smokers in the home? Yes No

Any antibiotics given? Yes No If yes, reason: _____

How would you describe your child's diet ?

Psychosocial Stressors

Any difficulties with lactation? Yes No _____

Any problems with bonding? Yes No _____

Any behavioral problems? Yes No _____

Any inattention? Yes No _____

Any hyperactivity or restlessness? Yes No _____

Any compulsiveness? Yes No _____

Any difficulties at school? Yes No _____

Any challenges with learning deficiencies? Yes No _____

Any night terrors, sleep walking, difficulty sleeping? Yes No _____

Any prolonged temper tantrums or separation anxiety? Yes No _____

Average number of hours of television per week? _____

Average number of hours of video games per week? _____

Does your child have a cell phone? Yes No How often do they text or use the phone? _____

Do you feel that your child's social and emotional development is normal for their age? Yes No

Thank you for completing this form. If you have anything to add below, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have, please discuss with the chiropractor.
