Welcome to think.

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)

think. Kohi Chiropractic

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Child (6-12 years) New Patient Information Todays Date_____

Childs name: _____ Nickname: _____

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

Home Phone Number: _____ Email :_____

Address: _____

Reason for visit: _____

Family Information

Parent name:_____ Parent 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:_____

Health History – Chief Complaint

What has brought the child into our practice today?_____

What do you think may have caused this problem?_____

_____

When did this problem begin?_____

Is the problem getting better, getting worse or unchanged since it began?_____

Was it: ☐ Sudden onset ☐ Gradual onset ☐ Result of an accident - if accident have you filled out an ACC form? Yes / No

Has the child had this complaint before in the past? ☐ Yes ☐ No If 'yes' then when?_____

Have you sought care for this problem previously? ☐ Yes ☐ No If 'yes' then when and with whom? (e.g. Physio, Osteo, G.P etc.)

_____

Does anything make the problem worse? ☐ Yes ☐ No If 'yes', what?_____

Does anything make the problem better? ☐ Yes ☐ No If 'yes', what?_____

Are there any daily activities that you cause difficulty or can no longer do?_____

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

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:_____

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

☐ early detection of problems ☐ prevention ☐ crisis management ☐ other _____

Any Other Health Concerns

_____

_____

When did this problem begin? _____

Is this problem: ☐ occasional ☐ frequent ☐ constant ☐ intermittent

What makes this worse? _____

What makes this better? _____

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

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

☐ 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

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

If yes explain_____

_____

Growth & Development History

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 (i.e.: cancer, hereditary conditions, diabetes, heart disease) that are present in:

Mothers family _____

Fathers family _____

Siblings _____

Physical Stressors

Any major falls ☐ 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 or bottle fed? _____ For how long?_____

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 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

Were there any difficulties with lactation? ☐ Yes ☐ No _____

Any problems with bonding? ☐ Yes ☐ No _____

Any behavioural problems? ☐ Yes ☐ No

_____

Any inattention? ☐ Yes ☐ No _____

Any hyperactivity or restlessness? ☐ Yes ☐ No _____

Any Impulsive/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.

_____

_____