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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Paediatric New Patient Information

Todays Date_____

Childs 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:_____

Pregnancy

During your pregnancy did mum have any of the following?

	Yes	No	(Please circle)
Falls	Y	N	
Motor vehicle accidents	Y	N	
High BP	Y	N	
Diabetes	Y	N	
Anemia	Y	N	
Morning sickness	Y	N	
Indigestion	Y	N	
Seizures	Y	N	
Swollen ankles	Y	N	
Thyroid problems	Y	N	
Heart problems	Y	N	
Back pain	Y	N	
Abnormal bleeding	Y	N	
Were you hospitalised	Y	N	
Other illnesses	Y	N	

During your pregnancy did mum use any of the following?

	Yes	No	
Tobacco	Y	N	
Alcohol	Y	N	
Non-prescribed drugs	Y	N	
Prescription medication	Y	N	
Over-the-counter medication	Y	N	

Labour and delivery

How long was the labour from first contractions to the birth? _____hours

How long was the second phase (pushing phase) of the labour?_____hours

	Yes	No	
Hospital birth	Y	N	
Home Birth	Y	N	
Midwife assisted	Y	N	
Obstetrician assisted	Y	N	

Vaginal Delivery	Y	N	_____
Planned C-section	Y	N	_____
Emergency C-section	Y	N	_____
Induced	Y	N	_____
Forceps	Y	N	_____
Vacuum extraction	Y	N	_____
Anaesthesia	Y	N	_____
Foetal distress	Y	N	_____
Meconium staining	Y	N	_____
Head presentation	Y	N	_____
Face presentation	Y	N	_____
Breech	Y	N	_____

Neonate Condition

Apgar Scores: 1 minute_____/10 5 minutes_____/10

Intensive care ·Yes ·No Days in intensive care unit_____days_____

Medication given at birth:_____ Vaccines administered_____

Birth weight_____lbs/kgs. Birth length_____ cms. Baby home on day_____

Sleep

How many hours does your child sleep? During the day?_____At night?_____

	Yes	No	
Do they have a preferred sleeping position?	Y	N	_____
Do they go to sleep easily?	Y	N	_____
Is sleep often disturbed?	Y	N	_____

Nutrition

	Yes	No	
Is/was your child still being breastfed?	Y	N	_____
If yes do they have a one sided preference?	Y	N	Left / Right

If yes for how long were they breastfed?_____

Is your child formula fed? Y N _____

Does your baby spit up after feeding?	Y	N	_____
Is your child eating solid food?	Y	N	_____
Does your child have any feeding difficulties?	Y	N	_____
Does you child have any digestive disturbances?	Y	N	_____
Does your child have any skin rashes?	Y	N	_____
Is your child taking vitamins or supplements?	Y	N	_____

What does your child normally eat for breakfast?_____

What does your child normally eat for lunch?_____

What does your child normally eat for dinner?_____

What does your child normally eat for snacks?_____

What is your child's favourite food?_____

What types of fast food does your child like to eat?_____

Trauma/Accidents

	Yes	No	
Has your child had any falls or trauma?	Y	N	
If yes describe the trauma and date it occurred?			_____
_____			
Has your child been in a car accident or near miss?	Y	N	_____
Has your child ever had a broken bone?	Y	N	_____

Health History

Yes	No	
Y	N	Has your child ever had colic? _____
Y	N	Has your child ever had upper respiratory infections? If So, how often?_____
Y	N	Has your child had asthma? _____
Y	N	Does your child ever complain of pain or discomfort? _____
		If yes when did this occur and in which body part? _____

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Specifically does your child ever complain of pain in the following areas:

	Yes	No	
Back	Y	N	_____
Neck	Y	N	_____
Arms	Y	N	_____
Legs	Y	N	_____
Ears	Y	N	_____
Head	Y	N	_____

Yes	No	
Y	N	Is your child allergic to anything? _____
Y	N	Are there smokers in the child's home? _____
Y	N	Has your child had any ear infections? _____
		If yes: When was the first one? _____ How frequently do they occur? _____

Yes	No	
Y	N	Is your child currently receiving any medications? _____
Y	N	Has your child ever been to an emergency room? _____
Y	N	Does your baby have a preferred head position? _____
Y	N	Does baby frequently arch his/her head and backwards? _____
Y	N	Has baby ever had a fever or illness? _____
Y	N	Has your child been vaccinated? _____

Do you have any other concerns? _____

_____