## Personal History

Child's Name _____ Date _____

Address _____

Suburb _____ State _____ Postcode _____

Date of Birth _____ ☐ Male ☐ Female

Parent's Name _____ Mobile Phone _____

Email _____

**** Please Select:*** ☐ I'd love to receive quarterly newsletters! ☐ Please only use my email for personal correspondence.

Were you referred to this office? If so, who referred you? _____

Why have you brought your child to see us? ☐ General check-up ☐ Help with a particular symptom/condition

(If particular symptom/condition) _____

_____

Has your child had previous Chiropractic care?

☐ No ☐ Yes – When was your child's last adjustment? _____

What type of birth did your child have?

☐ Normal Vaginal ☐ Breech ☐ Vacuum Extraction ☐ Caesarean ☐ Forceps

How many hours does your child sleep a night? _____

Describe the quality of your child's sleep: ☐ Good ☐ Fair ☐ Poor

When was your child last vaccinated? _____

Has your child been in a motor vehicle accident? ☐ No ☐ Yes – When? _____

Is your child sensitive to any of the following? ☐ Loud noises ☐ Crowded Places ☐ Light

☐ Other (please describe) _____

Has your child experienced any of the following? (Please provide relevant details)

- ☐ Colic or irritability _____
- ☐ Skin conditions _____
- ☐ Asthma or allergies _____
- ☐ Ear infections _____
- ☐ Behavioural or learning difficulties _____
- ☐ Recurrent/persistent colds or infections _____
- ☐ Difficulties falling or staying asleep _____
- ☐ Restricted movement of any part of the body _____

Parent's Signature _____ Date _____