Welcome to Casuarina Chiropractic

Your Baby's Health Profile

Ages 0 – 2

(Please complete ALL sections)

Your Baby's Name:			Date:
Address:	Suburb:		Postcode:
Home Phone:		Parent/ Guardian Mobile Phone:	
DOB:	Age: Sex: M / F	Parent/Guardian Email:	
Mum's Name:		Dad's Name:	
Siblings Names and Ages:			
Do you have Private Health Cover? Yes No		Which one?	
Your Baby's previous Chiropractor's name:			Date of last visit:
Who recommended you to our Centre?			

Even babies and young children have experienced many things that could cause spinal misalignments or 'VERTEBRAL SUBLUXATION'.
Vertebral Subluxation affects your child's nervous system, which affects your whole health, resulting in the unwanted conditions babies and children suffer from every day.

Please describe your **baby's health complaints** or reasons for consulting our office:

1._____for how long?_____

2._____for how long?_____

3._____for how long?_____

What do you think caused this problem(s)? _____

Your Baby's Birth

How long was the entire labour?_____ How long did you actually push?_____

Were you induced? Yes No Epidural? Yes No C-Section? Yes No

Was there any pulling on the head? Yes No Forceps or vacuum extraction used? Yes No

Were there any complications before/ during/ after the birth? Please describe briefly._____

_____

Please tick any of the following symptoms your baby has experienced:

- ☐ Poor Feeding patterns
- ☐ Often brings up feeds
- ☐ Poor Sleeping patterns
- ☐ Irritability/Restlessness
- ☐ Breathing problems
- ☐ Reflux/Colic
- ☐ Digestive problems/Gas
- ☐ Constipation/Diarrhoea
- ☐ Ear infections (Left / Right)
- ☐ Allergies/Rashes
- ☐ Recurrent colds/Flu

Is your baby breast fed? Y / N If so, does your baby have a side preference? Left / Right breast

Your Baby's Accident and Trauma History

Did you know…..47% of all children fall on their head by the age of one and they have at least 200 major falls by the age of 5 years old.

Early Childhood Injuries

Describe your baby's most recent falls/accidents/injuries.

1. When? _____ What happened? _____

Injuries? _____

Treatment? _____

2. When? _____ What happened? _____

Injuries? _____

Treatment? _____

Motor vehicle accidents

Has your baby been involved in a motor vehicle accident as a passenger? Yes No

Please describe briefly._____

Treatment given? _____

List **ALL** surgeries. _____

_____

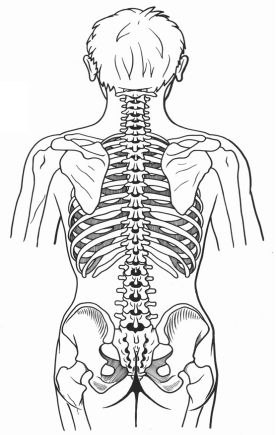
List **ALL** medications **past** and **present (including antibiotics)**.

_____

_____

I give permission for my child to have a thorough chiropractic examination, and chiropractic care if necessary, as indicated by the examination findings.

Parent/ Guardian Signature: _____ ***Date:*** _____



Office use only.

L ____ R ____

FHP L R Pronation L R VAT

Notes: _____

_____

R1 call: _____