Jackson Chiropractic 5941 5431 Infant and Child History: Birth to 12 years
jchiro@netspace.net.au 34 Jamie Ct, Pakenham 3810 jacksonboyle.com.au Practitioner: Dr Fiona Boyle

Personal Details: Name_____M/F ___DOB_____Age_____
Mum_____Dad_____Height:_____ Weight:_____
Address_____
Phone_____Mobile _____Referred by_____
Today's Date:_____Email_____Height_____Weight_____
Emergency contact full name: _____ Relationship:_____ Phone: _____
Previous Chiropractors Name:_____Phone:_____Address:_____

What concerns do you have regarding your child's health? Please describe in detail

_____

_____

When did it start_____**What helps**_____
What makes it worse_____
Medication/specialists/treatment_____
Describe in detail as much history as you can, leave blank areas that are beyond child's level
Your pregnancy-complications/stress_____
Labour Length_____Difficulties_____
Delivery: **eg vaginal/caesarian/forceps**_____
Medication_____
Intervention_____
Complications_____Resuscitation Y/N___Special Care Nursery Y/N
Sleeping_____
Feeding: breast feeding from birth Y/N Good painless attachment both sides Y/N_____
Was tongue tie checked? Y/N Breast feeding continued Y/N_____
Bowels_____Contentment/crying_____
Illnesses: eg. Respiratory/breathing issues/ear infections bronchitis_____
Posture lying down: curved to one side Y/N_____General muscle tone: tight/floppy_____
Head/neck full movement supine (on back) Right Y/N_____Left Y/N_____
Head/neck full movement prone (on tummy) Right Y/N_____Left Y/N_____
Hip movement forwards/backwards, Rotation in/out, buttock symmetry? Y/N _____Kicking Y/N_____
Full shoulder movement front and sides Right arm Y/N _____Left arm Y/N _____
Tummy time: lifting head_____Propping on forearms_____Weight on hands_____
Lifting head off floor supine (on back) _____ pulling feet up to hands_____
Speech development (refer to speech-language-therapy.com) RECEPTIVE_____
EXPRESSIVE_____
Rolling Front to back Y/N Right_____Left_____Rolling back to front Y/N Right_____Left_____
Tummy to sitting transferring Y/N _____ Do you prop child sitting with pillows? Y/N
Falls forward/backwards from sitting?_____
Sitting and propping with arm at side? Y/N _____Sitting-kneeling transferring Y/N_____
Seated Kneeling with knees together? Y/N_____ W sit? Y/N_____
Crawling Y/N N/A describe _____
Kneeling up_____ Kneeling to lunge on one leg Left: Y/N_____Right: Y/N_____
Squat to stand Y/N _____Even legs?Y/N upright back/spine Y/N_____
Standing holding on Y/N_____Feet posture?_____Cruising furniture Y/N_____
Use of walker Y/N _____ Pushing trolley Y/N_____ Walking unaided Y/N age_____
Significant injuries-**please describe/circle: falling off bed/stool/on tiles/down steps/play equipment/hitting head**
Falls_____Siblings handling_____Hit head_____Steps/stairs_____
Usual current diet: please list foods eaten (leave this section if only breast feeding) Please circle foods avoided
Breakfast_____ Lunch_____
Dinner_____Snacks_____
Drinks_____Avoid wheat sugar dairy colours flavours preservatives?
Stress- please describe: Family stress_____Siblings_____
Other_____

Name_____**Date** _____

0=no problems, 1=minimal 2=mild, infrequent, 3=mild frequent, 4=mild constant, 5=mod infreq, 6=mod frequent 7=moderate constant, 8=severe infrequent 9=severe frequent 10=severe constant

Stress:

Please rate out of 10 and describe with examples:

Coping_____Fear/clinginess_____

Behaviour_____

Anxiety_____Withdrawal_____

Concentration_____

Attention_____

Tantrums_____

Bowels_____Wet nights _____/7nights Wet in day _____

Sleep_____Tiredness/low energy_____

Immune system/digestion: skin, recurrent infections, allergies_____

Speech and eating: Please rate out of 10 and describe with examples:

Speech: _____Clarity_____

Mouth/tongue/jaw movements_____

Dribbling_____Chewing_____

Swallowing_____Biting_____

Face muscle movement _____

Jaw tightness/pain/teeth grinding_____

Shoulder and arm tightness with speech/eating_____

Hands-Fine motor: Please rate out of 10 and describe with examples:

Pencil grip_____

Handwriting _____

Posture/ pain at writing/sitting/computer_____

Creative writing/drawing _____

Feet: Please rate out of 10 and describe with examples:

Problems with walking_____

Shin pain_____

Balance & co-ordination running_____

Ankle twisting-rolling_____

Neck-Shoulder: Please rate out of 10 and describe with examples

Reading_____

Hand-eye tracking/co-ordination_____

Ball catching_____

Inner Ear-Neck-Eyes: Please rate out of 10 and describe with examples:

Balance _____

Distance, space, depth, speed judgement_____

Motion/car sickness_____

Vision_____

Sports performance_____

Posture: Standing_____Sitting: slumped Y/N_____"W" sitting_____

Walking posture_____Toe walking_____Heavy walking_____

Organisation and planning_____

Sacrum-Lower Spine-Legs: Please rate out of 10 and describe with examples:

Ability to sit still _____

Bladder/bedwetting_____

Copying from screen/board_____

Impulse control_____Sugar cravings_____

Info & Consent form - sign & bring to Jackson Chiropractic

Retained Neonatal reflex and NSA care are used at our centre , please follow links for info

-**contacts to your child's spine are light touch** and very precise. They should feel relaxing
-**respiration is used** with stretching to allow improved body movement
-**there is no manipulation** or "crunching", there is no massage
-**large muscles relax first** and improve tone to allow deep muscles to unlock
-**joints may release as your body improves muscle tone**, sometimes with a clicking noise
-**tension release is spontaneous and automatic** once your child's system is more co-ordinated
-**releases of stored pain, toxins and emotions** are common during and after visits, and are often severe. Major changes may make your child feel a lot worse for a few days.
-**the skills your child gains can be used at all times**, e.g. sleeping, playing, resting, learning.

Communication and privacy:

Ask as many **questions** as you need, you may also call, text, or email Dr Fiona between 9am-9pm

The **open plan room** is believed to improve results of unwinding and relaxation

If you prefer the **private room** at any visit or for all visits please advise when booking

Chiropractic care is not a substitute for medical diagnosis or emergency medical care

May Dr Fiona **discuss your child's progress** with-the person who referred you? Y/N

All health information is private and will not be shared with any third party without consent

Girls need to wear **bathers/bra crop top** with spine showing, **bike pants**, hair in a bun, Boys wear shorts or boxers, **bring fresh socks,** Bring snacks, toys, favourite blanket.

Make sure children are well rested, fed and hydrated and visit the toilet before adjustments

Please be responsible for **your child's behaviour around others in our centre,** and give them a break outside if they need some quiet time so as not to disturb others.

Parents: NO USE OF MOBILE PHONES IN ADJUSTING AREA

Please call as early as possible if you need to change appointment times, please be on time

Payment is expected at your visit; cash, cheque and EFT/credit and HICAPS available
Direct deposit (preferably in advance, please bring printout of receipt or text)
Account name: Jackson Chiropractic P/L CBA BSB 06 3733 Account number: 1031 1623

Fee Structure for consultations	***Concession/Child***	**Full fee**
First visit – History, Examination and Adjustments	***$110***	**$120**
Includes foot scan and posture photos, movement video analysis		
Regular Standard visit	***$55***	**$60**
Pre-payment option for 10 visits-save $50	**$500** ($50 x 10)	
Regular Family visit (4 or more family members)	***$220*** ($55 x 4)	
Concession fee for 4 members, plus others complementary		
Re-examination: Review, adjustment, report	***$110***	**$120**

(If refund of pre-paid fee is required, discount is removed before balance is paid to you)

▪I have understood this information, and agree to give my informed consent for care

Name…… Signature…… Date…….