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_____

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

Note: be aware that **Network care is different** from other types of chiropractic care
-**contacts to your spine are light touch** and very precise. They may be difficult to feel
-**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 release as your body improves muscle tone**, often with a popping noise
-**release of tension is spontaneous and automatic** once your system has connected more
-**releases of stored pain, toxins and emotions** are common during and after visits,
and are often severe. Major changes may make you feel a lot worse for a few days.
-**the skills you gain can be used at all times**, e.g. at home, work, when resting.
Please ask as many questions as you need, you may call, text, email Dr Fiona out of your visit time
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
health information is private and will not be shared with any third party without consent
Wear exercise type clothing. Avoid wearing strong perfume and aftershave
Posture photographs are taken, please wear fitted singlet or crop top, bike pants or shorts, bathers
Please don't smoke, take painkillers, or anti-inflammatories just before your visit
Make sure you are well hydrated and have been to the toilet
Please call as early as possible if you need to change appointment times

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 single visit……..	***$55***	**$60**
Pre-payment option for 10 visits-save $50……..	***$500***	**$500**
Regular Family visit-*maximum 5 immediate members same day*……	***$165*** ($55 x 3)	
(children under 18) concession for 3 members, 2 no charge		
Pre-payment option for Family 10 visits	***$1650***	
3 pre paid child fees, other members no charge ($45 x 3 per family visit or $45 x 30 individual visits)		
Re-examination: Review, adjustment, report……	***$110***	**$120**
Includes posture photos, movement videos**.** *Initially every 8 to 10 visits*		
(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
I understand that contacts will be gentle, precise, explained in advance and there will be time for rest and integration between contacts. It may involve positioning and stretching of limbs or my spine. Occasionally an adjusting instrument may be used with a very fast tap of low force.
It will involve my participation of awareness, breathing patterns, stretching, movement into comfortable positions, and feedback to my chiropractor during and after visits.
The moment I feel that any treatment needs to be explained further, modified or stopped, I will communicate this.
Name…… Signature…… Date……

Permission given for Dr Fiona to discuss your progress with-the person who referred you? **Y/N**; your family? **Y/N**