BURSWOOD HEALTH
PROFESSIONALS

File	Page

HOW CAN WE HELP YOUR CHILD? (under 2yrs)

Thank you for choosing Burswood Health Professionals to help you. We aim to provide top class evidence-based complementary and allied health care services focusing on both the acute care and wellness dimensions of health. We appreciate your patience in completing this questionnaire that asks about your child's problem. The information is necessary in assisting us to help your child. If you need help please ask, and remember this information is confidential.

Child's Full Name _____ Home Phone _____

Mum's name _____ Work Phone _____

Dad's name _____ Mobile Phone _____

Address _____ Email Address _____

_____ Postcode _____

Medical Practitioner _____ Health Cover _____

Recommended by _____

Has your child had chiropractic care before? Yes ❑ No ❑

Date of birth: _____ Age: _____ Height: _____ Weight: _____

Child's main symptoms: _____

Birth Weight: _____ Labour- length: _____ (Hours)

Please circle: Full term/Premature

Normal vaginal delivery/caesarean/suction/forceps/breech

As a baby did he/she: Sleep well? _____

Feed well? _____

Breast or formula fed? _____

Grow normally? _____

At what age did baby crawl? _____ Walk? _____

Please list broken bones: _____

Please list any major falls, accidents or injuries sustained:

If your child has been hospitalised, please list when and for what reason:

Has your child been immunised? Yes ❑ No ❑

Triple antigen ❑ Polio ❑ Tetanus ❑ Others _____

21 Harvey Street, Burswood WA 6100
Tel: 9361 2628, Fax: 9470 1185, Email bhp@highway1.com.au

What x-rays have been taken (if any)? _____

What vitamins or medication is your child taking or has taken in the past?

Current: _____

Past: _____

Does anyone smoke in your household? Yes ❑ No ❑

What sport does your child play? _____

Regarding each symptom, please tick (✓) the appropriate column:

	Never	Now	Past		Never	Now	Past
Asthma				Frequent colds			
Coughs				Allergies			
Earaches				Skin rashes			
Fever				Bed wetting			
Sore throats				Scoliosis (curvature)			
Tonsillitis				Poor sleeping			
Constipation				Hyperactivity			
Diarrhoea				Clumsiness			
Measles				Learning difficulties			
Poor appetite				Poor concentration			
Colic/reflux				Chicken pox			
Headaches				Stomach aches			
Mumps				Leg or growing pains			
Poor posture				Whooping cough			
Neck pain				Pneumonia			
Mid-back pain				Meningitis			
Low back pain				Glandular fever			
Epilepsy				Other illnesses			

Any other information regarding your child's health that we may need to know?

_____

_____

I understand that there is a fee for missed appointments. Payment is due when the service is performed. Payment for services can be made by cash, cheque, credit card or EFTPOS.

Parent / Guardian

Signature: _____ Date _____

Your Privacy is important to us. This information will be used in the interests of your continuing health care and will be safeguarded under our Practice Policy on Privacy, to which you can have access on request.

Office use only

Computer data updated __ Followup call ___ Thank-you Letter __ X-rays Developed __ X-ray Report __ ROF __ Client Card ___

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