LIGHT CHIROPRACTIC AND WELLNESS Shop 1/198-206 St Johns Road Glebe NSW 2037 t 02 9660 5055 f 02 9660 7677

Personal History (Children)

From birth, and even earlier, we interact with our environment and its variety of sensations and experiences. The stresses and challenges encountered can be physical, chemical or emotional. Sometimes we are unable to deal with the full effect of an event at the time it occurs. Regardless of whether the experience was a positive or negative one we can then hold on to it physically, emotionally or mentally. The care your child receives here will help them release this stored energy which can create tension, discord and dis-ease in the body, interfering with its self-healing capacity. At Light Chiropractic and Wellness we use a gentle chiropractic method to release this interference, allowing the body's communication systems to function more effectively. Information about the pregnancy, your child's birth and health history will help to give us a clear understanding of any stresses your child has experienced.

Child's Name .... Client Number .... Date ....

DOB .... Parent's Name .... Telephone Number ....

Address ....

Suburb .... State .... Postcode ....

Email ....

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

Please describe ....

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Where was your child born? ☐ Hospital ☐ Home ☐ Birthing Centre ☐ Other ....

How long was the labour? (time from first contraction until birth) ....

Was your child? ☐ Early ☐ On time ☐ Late Child's birth weight .... Child's birth length ....

How was your child delivered? ☐ Natural/vaginal ☐ Caesarian (planned) ☐ Caesarian (emergency)

How did your child present? ☐ Crown/top of head first ☐ Face first ☐ Breach ☐ Other ....

Were any of the following interventions used? ☐ Epidural ☐ Induction ☐ Forceps ☐ Suction ☐ Other ....

According to your midwife/obstetrician, did your child become distressed at any time? (Please describe any relevant details) ....

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Did you experience tearing of your pelvic floor? .... Number of stitches required ....

Did you experience any of the following during your pregnancy? (provide relevant details)

☐ Falls ....

☐ Accidents ....

☐ Significant emotional stress ....

☐ Illness ....

☐ Morning sickness ....

☐ Exposure to toxins ....

☐ Fears about the health/survival of your child ....

☐ Back or pelvic pain/discomfort ....

Any other children (ages) ....

At present, describe yourself: ☐ Happy/relaxed ☐ Stressed/anxious ☐ Emotionally up and down ☐ Other ....

Do you feel you have enough support from your partner, family, friends, etc? (provide relevant details) ....

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Have you experienced significant hardship or stresses since your child's birth? (provide relevant details) ....

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

☐ Falls/accidents ....

☐ Illnesses ....

☐ Major stresses (eg parent separation) ....

☐ Death of a family member/friend ....

☐ Witnessed a trauma ....

☐ Birth of a sibling ....

☐ Change in living arrangement ....

☐ Other ....

Has your child been diagnosed with any condition, disorder or disability not previously mentioned? (provide relevant details) ....

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List any vaccinations your child has received, and their age at the time ....

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Was your child breastfed? .... Are they still being breastfed? ....

Briefly describe your child's diet now (eg breast milk, formula, mashed vegetables, meat, etc) ....

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Does your child have any food sensitivities or intolerances that you have noticed? (please describe) ....

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Briefly describe your child's sleeping habits (eg restlessness, waking in the night, sleeps soundly) ....

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Is your child sensitive to any of the following: ☐ Loud noises ☐ Crowded places ☐ Light ☐ Other ....

Has your child experienced any of the following? (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 ....

In general, how would you describe your child? (eg happy, relaxed, stressed, anxious, aware, etc) ....

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Is there any other information that hasn't been covered which may help us to better understand your child? ....

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Important Information

Many people come to our office when they are feeling great and some visit us for health conditions like back pain, headaches, digestive problems, emotional problems, etc. However, please remember that the aim of chiropractic is not the treatment of disease or conditions, but rather the optimisation of your child's health. Sometimes people notice their body detoxifying after adjustments, which can express itself as headaches etc. You, or your child, may also at times notice old aches and pains resurfacing or emotions releasing. This is all part of working with stored tensions and energy in the body. As your child's experiences and perceptions change with this work their life will change.

Parent's Signature .... Date ....