Office use Only:
Your chiropractor is
☐ Joe Williams
☐ Zoe Pantelios
CA _____

Referral Source:
☐ Internet
☐ Facebook
☐ Twitter
☐ Google
☐ Friend / Family
☐ GP / Midwife
☐ Leaflet
☐ Talk / Event

Paediatric Registration Form

Please answer all the questions so we can assess how we can best help you

Patient Information

Child's Name _____
Address _____
County _____
Home Phone _____
Mobile Phone _____

Is it okay to contact you at work?:
☐ Yes ☐ No

Have you or your child ever had chiropractic care before?
☐ Yes ☐ No
If yes, please tell us the chiropractor's name _____

Is your child receiving care from other health professionals?
☐ Yes ☐ No
If yes, please name them and their speciality _____

Parent(s)/Guardian(s) Name _____
City/Town: _____
Postcode _____
Work Phone _____

Email _____
☐ I give my consent to be added to the email newsletter to receive recent news, events and healthy tips.

Birth Date _____
Age _____

How did you find out about our practice _____

Who is your family's GP? _____

How can we help your child?

What health condition brings your child to our practice?
_____

When did the symptoms first begin? _____

How did the problem start?
☐ Suddenly ☐ Gradually ☐ Post-Injury

Is this Condition?
☐ Getting Worse ☐ Improving ☐ Intermittent
☐ Constant ☐ Not Sure

What makes the problem better? _____
What makes the problem worse? _____

Has your child ever had a similar condition?
☐ Yes ☐ No
Please explain _____

Has your child been treated for this before?
☐ Yes ☐ No
Please explain _____

Does your child eat well?
☐ Yes ☐ No

Does your child have regular bowel/bladder movements?
☐ Yes ☐ No

Has your child ever been checked for spinal fixations?
☐ Yes ☐ No ☐ Don't Know

Birth History

Type of birth (check all that apply)
☐ Hospital ☐ Birth Centre ☐ Home ☐ Normal/Vaginal
☐ Breech ☐ Caesarean ☐ Scheduled/Induced
☐ Epidural

Problems during labour/delivery?
_____

☐ Antibiotics ☐ Congenital Anomalies ☐ Failure to Thrive
☐ Jaundice ☐ Meconium ☐ Respiratory Distress
☐ Extended Hospitalization
☐ Other _____

Pregnancy History

Did you experience any complications during your pregnancy?
(Check all that apply)
☐ Back/Other Pain ☐ Gestational Diabetes ☐ Pre/Eclampsia
☐ Strep B ☐ Nausea/Vomiting ☐ Pre-Term
☐ Fatigue ☐ Swelling
☐ Other (please describe)
_____

Pregnancy History Continued

Did mother smoke during pregnancy?
☐ Yes ☐ No

Did mother drink alcohol during pregnancy?
☐ Yes ☐ No

Any illness of mother during pregnancy?
☐ Yes ☐ No
If yes, please explain including treatment/medications/supplements
_____

List any drugs/medications (including over the counter) taken during pregnancy
_____

List any supplements taken during pregnancy
_____

Any exposure to ultrasound?
☐ Yes ☐ No
If so, how many and what was the medical reason?
_____

Growth and Development

Was your child alert and responsive within 12 hours of delivery?
☐ Yes ☐ No
If no, explain _____

At what age did the child:
Respond to sound _____ Vocalise _____
Follow an object _____ Roll over _____
Hold head up _____ Sit alone _____

Did your child:
☐ Cross Crawl ☐ Bum Shuffle
☐ Commando Crawl ☐ Didn't crawl

Patient/Hospitalisation/Surgical history (please list below all surgeries and hospitalisations, including the year)

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

Is/was your child breastfed?
☐ Yes ☐ No
If yes, how long? _____

Did the mother experience any difficulties?
_____

Was the baby tongue tied?
☐ Yes ☐ No

Formula introduced at age _____
What type? _____
Introduction of cow's milk at age _____
Began solid foods at age _____
They started eating _____
Please list any foods/juice intolerance
_____

Has the child received any vaccinations?
☐ Yes ☐ No
If yes, which ones and list any reaction
_____

Has your child received any antibiotics?
☐ Yes ☐ No
If yes, how many times and list the reactions
_____

Has there been any difficulty in breastfeeding?
☐ Yes ☐ No
If yes, please explain
_____

Has there been any difficulty in bonding?
☐ Yes ☐ No
If yes, please explain
_____

Are there any behavioural problems?
☐ Yes ☐ No
If yes, please explain
_____

Any night terrors, sleepwalking, difficulty sleeping or bed wetting?
☐ Yes ☐ No
If yes, please explain
_____

Age the child began nursery _____
Average number of hours in front of TV, iPads, phones a day _____

Does your child seem normal for their age?
☐ Yes ☐ No
If no, what are your concerns?
_____

Family History Review

Please tick those involving immediate family and add identification:

M = Mother **F** = Father **S** =Sibling **G** = Grandparents

☐ **Cancer**, type_____
☐ M ☐ F ☐ S ☐ G

☐ **Heart Disease**
☐ M ☐ F ☐ S ☐ G

☐ **Lung Problems**
☐ M ☐ F ☐ S ☐ G

☐ **Seizures/Epilepsy**
☐ M ☐ F ☐ S ☐ G

☐ **Depression**
☐ M ☐ F ☐ S ☐ G

☐ **Liver Disease**
☐ M ☐ F ☐ S ☐ G

☐ **Scoliosis**
☐ M ☐ F ☐ S ☐ G

☐ **Osteoarthritis**
☐ M ☐ F ☐ S ☐ G

☐ **Diabetes**
☐ M ☐ F ☐ S ☐ G

☐ **High Blood Pressure**
☐ M ☐ F ☐ S ☐ G

☐ **High Cholesterol**
☐ M ☐ F ☐ S ☐ G

☐ **Rheumatoid Arthritis**
☐ M ☐ F ☐ S ☐ G

☐ **Back Problems**
☐ M ☐ F ☐ S ☐ G

☐ **Neck Problems**
☐ M ☐ F ☐ S ☐ G

☐ **Headaches/Migraines**
☐ M ☐ F ☐ S ☐ G

☐ **Osteoporosis**
☐ M ☐ F ☐ S ☐ G

☐ Other
_____

Chiropractic and You

Do you know much about chiropractic?
☐ Yes ☐ No
Explain _____

Do any of your friends or their children receive chiropractic care?
☐ Yes ☐ No
If yes, do they use chiropractic for
☐ Health maintenance and wellness ☐ Health problems
☐ Both

Do you belong to any local mother and baby groups?
☐ Yes ☐ No
Which ones? _____

What would you like to gain from chiropractic care?
_____

What are your fears, worries or concerns about chiropractic?
_____

What are your expectations for chiropractic?
_____

Are there any health concerns or anything else you would like your chiropractor to understand about your child?
_____

Filling out this form digitally?
When you have completed the form simply save it and send the same PDF file back to Tunbridge Wells Community Chiropractic by email:
hello@twcchiropractic.co.uk