MERN CHIROPRACTIC	CHILD'S NAME
	MOTHERS'S NAME
	FATHER'S NAME
ADDRESS	
POSTCODE	CHILD'S D.O.B.
PARENT'S OCCUPATION	EMAIL
PHONE	MOBILE
G.P. NAME / SURGERY ADDRESS	
HEALTH VISITOR	MIDWIFE
NAMES & AGES OF SIBLINGS (IF ANY)	

PRE-NATAL / BIRTH HISTORY		
Any maternal illness or drugs during pregnancy?		
Number of previous pregnancies:	Number of ultrasound scans:	
Duration of birth (from labour onset):	2nd Stage:	
Length at birth:	Weight at birth:	
Head circumference:	AGPAR Score:	
Was the birth (circle all that apply):		
Premature	Due Date	Overdue
Vaginal (no assistance)	Vaginal (induced)	Forceps
Ventouse	Breech	Face or forehead presentation
Planned Caesarean	Emergency Caesarean	
Did the baby have:		
Bruising	Jaundice	Special Care
Is the baby:		
Breastfed	Bottlefed	Both
Milestones (tick if achieved, cross if not achieved yet)		
6 weeks	Smiling	
3 months	Head steady	
7 months	Sits unaided	
9 months	Stands unsupported	

11 months	Crawling	
12 months	2 or 3 recognisable words	
14 months	Walks unaided	
16 months	Holds and drinks from a cup	

PRESENTING COMPLAINT			
What is the present complaint?			
Have you consulted anyone else?			Y / N
Is your baby on any medication?			Y / N
Has your baby had any medical treatment / scans / x-rays / surgery?			Y / N
Are you on any medication?			Y / N
Was your baby born with any congenital disorder?			Y / N
Is there any family history of illness?			Y / N
Has your baby had any vaccinations?			Y / N
If yes, were there any reactions?			Y / N
Has your baby had any childhood illnesses or allergies?			Y / N
Are there any feeding difficulties?			Y / N
Is baby easy to wind?			Y / N
Has your baby been checked for tongue tie?			Y / N
How long does your baby normally sleep on average (hours)?			
Do they use a dummy?			Y / N
Constant crying?			Y / N
How often does your baby have bowel movements?			
How many wet nappies a day?			
Does baby have a head preference?	Right	Left	None
Does your child sleep on their back?	Yes	No	Most of the time
How much tummy time does your baby get currently?			
What do you hope to get from chiropractic care?			

INSURANCE INFORMATION	
Do you have private health insurance?	**Y / N**
If **Yes**, please give name of provider:	

PARENTAL CONSENT	
I have received a full explanation of my baby's condition	**Y / N**
I have had the opportunity to ask questions	**Y / N**
I have been advised of all treatment options and likely benefits	**Y / N**
I have been advised of possible side effects associated with treatment	**Y / N**
I am happy for a full report to be sent to my GP	**Y / N**
I consent to chiropractic treatment for my baby	**Y / N**
I consent to all data being kept on electronic data base (more info below)	**Y / N**

I hereby give my consent for my child to be examined by the Chiropractor using chiropractic methods as seen fit.

Signed (Parent/Guardian)..... **Date** .....

Print name : .....

DATA PROTECTION

Under the GDPR (2018) regulations we are required to advise you of our Data Protection Policy which is available in full by request or on our website. We process your data in lawful and transparent manner. We only gather information that we need, it will always be available to you free of charge and it is securely stored. As part of the patient record, this clinic is required to retain information for the purpose of consultation, for treatment, recording subsequent treatments and for the use by third party medical practitioners only at the request of the patient in writing. Upon completion of this form all paper files and electronic records will be kept for as long as the patient remains a patient of the clinic and thereafter for a period of 7 years. All information is confidential and will not be given to any person or organisation without the written consent of the patient concerned. All data is held either electronically or on paper in files accessible only by clinic staff who are directly involved in the data entry and processing of patient records.