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?		
Milestones (tick if achieved, cross if not achieved)		
7 -9 months	Sits unaided	
9 -12 months	Stands unsupported	
11 months	Crawling	
14 months	Walks unaided	
2 years	Speech	
3 years	Self-dressing	

PRESENTING COMPLAINT	
What is the present complaint?	
Have you consulted anyone else?	Y / N
Is your child currently on any medication?	Y / N
Has your child had any medical treatment / scans / x-rays / surgery?	Y / N
Was your child born with any congenital disorder?	Y / N
Has your child had any vaccinations?	Y / N
If yes, were there any reactions?	Y / N

Has your child had any childhood illnesses or allergies?	Y / N
Does your child have a good diet?	Y / N
Which sports activities does your child do?	Y / N
Regular bowel movements?	Y / N
Does your child sleep well?	Y / N
Physical Development (weight/height gain etc.)	
Has your child had any significant falls/ accidents?	Y / N
Has your child broken/fractured any bones?	Y / N
Has your child had any antibiotics?	Y / N
Has your child taken any other prescription medication?	Y / N
Does your child take any vitamin or mineral supplements?	Y / N
How would you describe your child's emotional/mental health?	
How would you describe your child's activity level?	
Family history of medical problems?	
Number and ages of siblings:	

OTHER PROBLEMS			
Is your child experiencing or ever experienced (please circle all that apply):			
Constipation	Diarrhoea	Hyperactivity	Attention Issues
ADHD Diagnosis	Concentration Issues	Learning Difficulties	Behavioural Problems
Balance/Coordination Issues	Autistic Spectrum Disorder Diagnosis	Recurrent Colds	Ear Aches
Asthma	Scoliosis	Growing pains	Headaches
Back Pain	Neck Pain	Sinus Problems	Bedwetting
Night Terrors	Joint Problems	Clicky Hip	Convulsions
Tonsillitis	Chronic Fatigue	Food Intolerances	Dislikes/Issues w/Food
Any other information you think might be relevant?			

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

PARENTAL CONSENT & DATA PROTECTION

I hereby give my consent to physical examination for my child by the Chiropractor.

Parent / Guardian ..... Date.....
(Signature)
(Print Name).....

Under the Data Protection (1998) Act, we are required to retain information for the purpose of consultation for treatment, recording subsequent treatment, and for the use of third party medical practitioners only, at the request of the patient, in writing.
Upon completion of the Patient Details Form, Data Protection and Consent forms, all paper files and information therein may be electronically scanned and stored on computer file for as long as the patient remains a patient of the Clinic, and upon completion of treatment for a period of no less than 8 years thereafter.
All information are held in files only accessible by the staff of the Clinic, who are directly involved in the data entry and processing of patient records. I, the undersigned (Parent/Guardian), acknowledge that I have read the Data Protection Policy (above) and do hereby give consent to the Chiropractor to maintain records for the purpose outlined within the policy

Parent / Guardian ..... Date.....

I have read the information sheet and leaflets and been given a Report of Findings regarding my child's condition.
I have had the opportunity to ask questions and been advised of all treatment options available. I have been advised of possible side effects associated with treatment. I consent to chiropractic treatment for my child as outlined to me.

Signed..... Date.....