Case No	
Date	
DC	

Orchard Chiropractic Centre Paediatric Introductory Form

Child	Full name:	DOB/age:	
Mother	Full name:	DOB/age:	
Tel work/mobile:		Occupation:	
Father	Full name:	DOB/age:	
Tel work/mobile:		Occupation:	
Home Address			
Name/Add/Tel GP:			
		Last GP visit:	
Recommended by:		Health Ins. Co:	

Medical History

Does/has your child suffered from problems with any of the following? (please tick, details asked later)

☐ eye / vision	☐ lung / breathing	☐ epilepsy
☐ ear / hearing	☐ skin problems	☐ heart disease
☐ nose bleeds / nasal obstruction	☐ TB	☐ chest pain / palpitations
☐ facial pain	☐ sore throats	☐ stroke
☐ encephalitis / meningitis	☐ sinus	☐ fainting / dizziness
☐ indigestion / heartburn	☐ diabetes	☐ allergies
☐ vomiting / nausea	☐ gall stones / jaundice	☐ joint pain / swelling
☐ irritable bowel syptoms	☐ kidney / bladder	☐ loss of weight / energy
☐ haemorrhoids	☐ sleep disturbance	☐ cancer

Please list any medication being taken by your child at present

Please give details if your child has...

...broken any bones

...had any accidents eg. car/sport/falls

..ever had major medical traetment/tests/surgery

Do you consider your child to be in good health

Do you consider your child to be under stress? school/family

Is there anything else you feel you should mention about your child's health?

Dental History

Name/Address of dentist:

Does your child...

- ...suffer with jaw pain / clicky jaw / lock jaw? ☐
- ...grind your teeth? ☐
- ...wear a dental appliance / dentures? ☐

Has your child...

- ...worn an orthodontic brace? ☐
- ...had dental surgery? ☐
- ...had any permanent teeth removed? ☐

Reason for today's visit

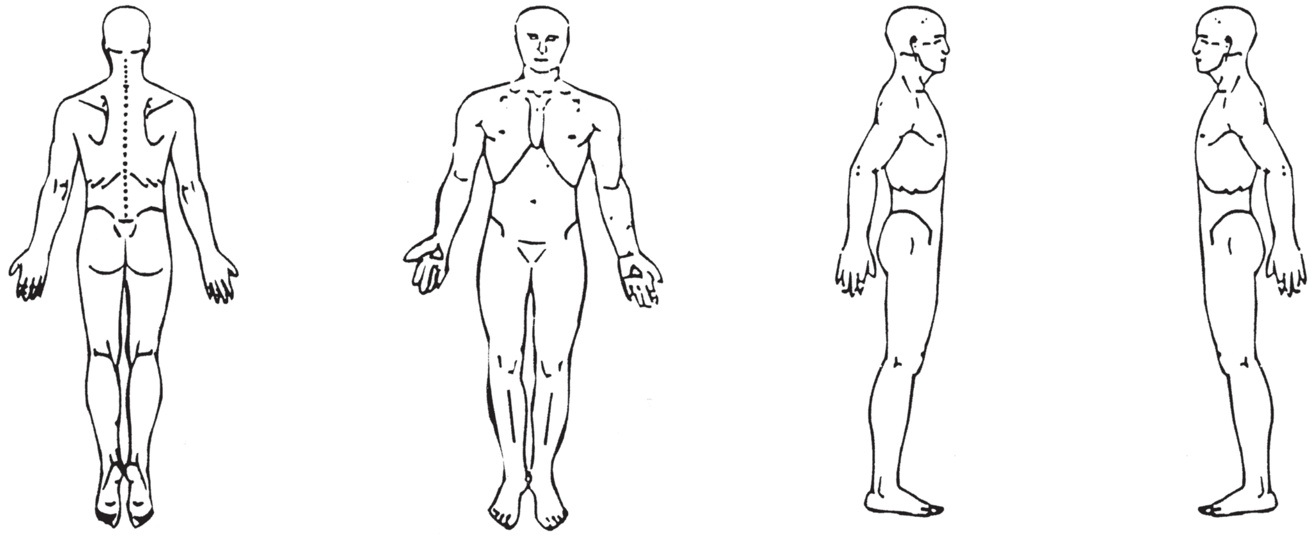
What symptoms, if any, does your child have?

Have they had any tests/diagnosis/treatment for these?

If your child is experiencing discomfort, where on a scale of 0-10 would you / they rate it? X at worst O at best

0 1 2 3 4 5 6 7 8 9 10

Please indicate, if appropriate, where your child has a complaint/s



Have you or your child received Chiropractic care before? If so, where and when?

Are you looking for:

☐ Just pain relief? ☐ pain relief and optimum corrective care? ☐ To maintain your child's health after this episode?

Data Protection

The requirement of data protection that we have written permission from you to allow us to communicate with other professionals involved in the child's health care. Please sign below if you are happy for us to do this.

Signed (by parent/Guardian) .... Date ....