Health History

Birth Type (check box)

☐ Short ☐ Long ☐ Difficult

☐ Natural ☐ Forceps ☐ Don't Know

☐ Home ☐ Hospital Birth Weight

Has your child:

Been involved in any motor vehicle accidents?

☐ Yes ☐ No

Had a fall onto their head?

☐ Yes ☐ No

Had any hard falls while learning to walk?

☐ Yes ☐ No

List significant falls or other accidents (please describe)

List operations/hospitalisations/serious illnesses

List medications

During pregnancy did you:

☐ Smoke/Drink ☐ Have any falls

☐ Eat a balanced diet ☐ Experience mental or physical abuse

☐ Excercise ☐ Feel emotionally stressed

Was your child breastfed? ☐ Yes ☐ No

At what age did your child learn to:

Sit Crawl Stand Walk

Is your child experiencing any of the following?

Symptom	Yes	Explanation
Vision	☐	/
Vertigo	☐	/
Vomiting	☐	/
Nausea	☐	/
Auditory	☐	/
Not sleeping	☐	/
Not feeding well	☐	/
Digestion/Intestinal	☐	/
Circulation	☐	/
Heart	☐	/
Diabetes	☐	/
Stomach	☐	/
Nose/Throat	☐	/
Lungs	☐	/
Skin	☐	/
Colic	☐	/

Symptoms are affecting other aspects of child's life

☐ School ☐ Sleep ☐ Sport ☐ Family

☐ Emotional ☐ Other

Financial Responsibility

I acknowledge that payment is due on the day of consultation unless prior arrangement has been approved.

SIGNATURE DATE