Here at Waters Family Chiropractic, our goal for anyone we accept under our care is to help you live your best life. Whether that's helping to reduce pain or discomfort, alleviating various symptoms, improving function or restoring health, we are here to help.

For us to fully understand why you are here, your child's overall state of health and to make sure you're in the right place, we have a series of questions for you below. We appreciate you filling this form out to the best of your ability. Thank you, and welcome!

Your Details

Surname: _____ Given Names: _____

Parents Names:_____ Are they the child's guardian? ▫ **Yes** ▫ **No**

Names and ages of siblings: _____

Address: _____ Suburb: _____ Postcode: _____

Phone: (M)_____ (W)_____ (H) _____

Email: _____ Date of Birth: _____

Age: _____ Weight: _____ Height: _____

Who recommended you to us?_____

Your Preferred Method of Contact: ▫ Phone ▫ SMS ▫ Email

How Can We Help You?

What brings you in today? _____

_____

If you have no symptoms or complaints and are here for a Spinal Wellness Check please tick ▫ **OR** if you are already experiencing symptoms, what are they?

_____

_____

When was the first time you noticed it? _____ How many times has it occurred since? _____

Is getting ▫ **Worse** ▫ **Better** ▫ **Staying the same**?

How is this problem affecting your life? _____

Have you seen anyone in regards to this concern before? ▫ **Yes** ▫ **No**

Practitioner Type? _____ Were you happy with the result? _____

Have you ever seen a Chiropractor before? ▫ **Yes** ▫ **No**

When was your last adjustment? _____ Who was the Chiropractor? _____

Were X-Rays Taken? ▫ **Yes** ▫ **No** Were you happy with your chiropractic care? ▫ **Yes** ▫ **No**

Comments? _____

	Past	Present
Ear Disorder/ Infections		
Sinus Trouble		
Hay Fever		
Nervousness		
Headaches		
Migraines		
Trouble Sleeping		
Dizziness / Vertigo		
Loss of Balance		
Allergies		
Recurrent Sore Throats		
Eczema/Skin Rash		
Asthma		
Colic		
Chronic Cough		
Stomach Tension		
Poor Balance		

	Past	Present
Bloating		
Nausea / Vomiting		
Constipation		
Diarrhoea		
Urinary Problems		
Bladder Weakness		
Chronic UTIs		
Bed Wetting		
Period Trouble/ Cramping		
Growing Pains		
Irritability		
Fatigue		
Jaw Problems		
Co-ordination		
Learning Difficulties		
Attention Deficit		
Epilepsy		

	Past	Present
Soreness in Neck		
Shoulder Pain		
Shoulder Tension		
Arm Pain		
Pins & Needles		
Mid Back Pain		
Mid Back Tension		
Pain In Ribs		
Low Back Pain		
Low Back Weakness		
Low Back Stiffness		
Buttock Pain		
Leg Pain		
Leg Cramps		
Restless Legs		
Knee Trouble		
Foot Trouble		

Dysfunction in your spine and nerves might affect various systems of the body. Please tick to indicate if you have noticed the following problems in either the past or present.

Previous Stressors:

Birth Process	YES	NO
Long Delivery		
Difficult Delivery		
Forceps/Vacuum		
Head Bruising		
Caesarian		
Breach		
Induced Labour		
Drugs During Labour		
Drugs during Delivery		

As a Baby	YES	NO
Was breastfed		
Was a Head Banger		
Fell on Head		
Fell down stairs		
Crawled Properly		
Walked Properly		

Our health is often dependent on things that have happened in the past. Has your child ever had:

	No	Yes	Age	Brief Details
A car accident				
A broken bone				
Been knocked unconscious or a fall from >1m				
Any major Illness				
Been hospitalised or surgery				
Any other physical or emotional trauma				

Current Lifestyle Stressors:

Our health is greatly affected by *current* lifestyle stressors, which fall into 3 broad categories: Physical, Chemical, and Emotional. Please tick any that apply to you:

Physical	*Chemical*	*Emotional*
_____ Computer work	_____ Unhealthy Food	_____ School
_____ Poor fitness	_____ Not enough water	_____ Family
_____ Sport	_____ Prescription medication	_____ Relationships
_____ Sleep posture	_____ Sugar	

Other: _____

Your Goals and Health Objectives:

What are your goals for your child with us? (Tick any that apply)

_____ Short-term relief of symptoms
_____ To correct the underlying cause of my symptoms and health issues
_____ To prevent development of symptoms and health problems in the future
_____ To achieve an optimum level of health and well-being (ie. Live life to the fullest!)
_____ To improve and correct my posture

Any others: _____

Examination and Radiological Consent

I consent to a professional and complete chiropractic examination. I understand that Radiological Examination (X-Ray) of the spine may be recommended by my chiropractor as part of my examination. Any proposed imaging procedures will be explained in full.

Signature _____ Date _____

WELLNESS SURVEY

Please mark on the line below with a vertical dash "I" to show how you would rate these questions.

Please think about how you are feeling right now, your general sense of health and well-being.

Worst you could possible feel **Best you could possibly feel**
1_____10

Please think about how energetic or vital you have felt over the last week.
No energy at all **Most energetic you could possibly feel**
1_____10

Think about how good your ability to concentrate has been over the last week.
No ability to concentrate **Best possible ability to concentrate**
1_____10

Please think about how your mood has been over the last week.
Worst mood possible **Best mood possible**
1_____10

Please think about how well you have slept over the last week.
Worst sleep possible **Best sleep possible**
1_____10

Please think about how strong your resistance to coughs, colds and other infections has been over the last 3 months.
Worst resistance possible **Best resistance possible**
1_____10

Is there any reason that this is not an accurate reading of how you usually feel

_____

_____

_____