Welcome to **SYNON** chiropractic

Child's name: ____________________________________ Date: ____________
D.O.B ____/____/____ Age: __________
Mother's name: ______________________ Father's name: ______________________
Address: ____________________________________ Postcode: _________
Phone: (Hm) _______________ (Wk) _______________ (Mob) ____________________
Please list other children (including ages) ______________________________________
____
Who may we thank for referring you to us? _____________________________________

	Reason for appointment & related health problems	Date started or for how long
1.	___________________________________	___________________
2.	___________________________________	___________________

Has your child had chiropractic care before ? Yes _____No _____ When _____________
Who was the Chiropractor ? _______________________________
Name of Medical Doctor. _______________________________

Your Child's Health History

Type of birth:

Normal Vaginal_______ Forceps _______ Breech _______ Caesarean ______
Home _______ Hospital _______ Birth Centre _______

Please circle the following conditions your child has or still suffers from;

Allergies / Rashes	Backaches	Hyperactivity
Ear / Throat Infections	Neck pain	Constipation / Diarrhea
Chest Infections	Headaches	Colic
Asthma	Digestive problems	Milk / Lactose Intolerance

Please list past & current medications: ____

Please list previous surgeries & dates: ____

Has your child had any vaccinations? Yes _______________ No ________________

Did he/she have any reactions to them? Yes _______________ No ________________

If yes, describe ____

Has your child had any significant falls or accidents? Yes __________ No __________

If yes, please list ____

____

Signature of parent / guardian ____