Body Brilliant Pediatric Acquaintance Form

Welcome to Body Brilliant Chiropractic, thank you for entrusting us with the health of your little one, you are in the right hands. All information you provide us is strictly confidential. If you need help with a question, please feel free to ask one of our friendly team.

Today's appointment is so we may find out everything we can about you child, their health concerns & for us to conduct any necessary testing, to determine if Chiropractic can help them.

In order for us to provide you with the results of this testing, a recommendations report will be scheduled with the Doctor.

Full name_____ Date_____
Postal address _____
_____Postcode _____
Telephone H _____ W_____ M _____
Email_____Parent/Guardian name_____
Date Of Birth_____Age_____Birth Weight_____
Current Weight_____M or F
Who can we thank for referring you to Body Brilliant/where did you find out about us?_____
Do you have a Medicare card? Yes / No
What is your relationship to this child?_____

What is the main reason for your visit to Body Brilliant today?_____
_____
_____

Obstetrician/Midwife:_____Phone:_____
Pediatrician/Family GP:_____Phone:_____
Date of last visit to your GP: _____Purpose_____
Immunization History:_____

Did your baby have any reactions following any of their vaccinations?_____
_____

Pregnancy & Birth

The birth process, can be a major source of trauma to a babies spine & nervous system, please give us details around your birth. Tick any which are applicable.

☐ Normal Vaginal ☐ Forceps ☐ Breech ☐ Emergency Cesarean
☐ Elective Cesarean ☐ Vacuum Extraction ☐ Epidural ☐ Induction

What was your due date?_____When was your baby born?_____
Did you have any problems during your pregnancy?_____
_____
_____
If you were induced, how far past your due date did this happen?_____
If your baby was either a forceps or vacuum extraction birth, was there any bruising or injury?_____
_____
How long was your labor?_____
How was your birth?_____
_____
_____

Infant Feeding

Please select how you are currently feeding your baby

☐ Breast ☐ Bottle ☐ Formula

If your baby is on formula, how long has It been on formula for?_____
Did you notice any change in their digestion or behavour when beginning formula?_____
# of hours sleep per night: _____ Quality of Sleep: ☐ Good ☐ Fair ☐ Poor

If you breastfeed, do you notice if your baby feeds better on one side compared to the other? If yes, which side?_____
Have you introduced solids to your baby? If yes, since what age?_____
What is an example of a typical days food for your child?_____

_____

_____

How often does your child have a bowel movement?_____
Do they strain, or are they in discomfort while having a bowel movement?_____

Trauma

By the age of one, the average baby has had a fall from a height, be it a bed, lounge or change table. Please list any falls, bumps or traumas that your child has had and the dates of them.

_____
_____
_____
_____
_____

Health History

Please tick any health concerns your child has experienced and describe below:

☐ Dizziness	☐ Backaches	☐ Heart Trouble	☐ Chronic Earaches
☐ Diabetes	☐ Tuberculosis	☐ Hyper Tension	☐ Colds/Flu
☐ Arthritis	☐ Headaches	☐ Asthma	☐ Allergies
☐ Neuritis	☐ Digestive Disorders	☐ Sinus Trouble	☐ Constipation
☐ Anemia	☐ Rheumatic Fever	☐ Orthopedic Problems	☐ Diarrhea
☐ Poor Appetite	☐ Hyperactivity	☐ Sugar Concentration	☐ Behavioral Problems
☐ Bed Wetting	☐ Convulsions	☐ Paralysis	☐ Muscle Jerking
☐ Fainting	☐ Walking Problems	☐ Broken Bones	☐ Ruptures / Hernias
☐ Neck Problems	☐ Arm Problems	☐ Leg Problems	☐ "Growing Pains"
☐ Joint Problems			

Medications

Please list any medications your child has been on (including antibiotics) and the reason for the medication:

_____
_____
_____

Has your child been treated on an Emergency Basis? (please describe):_____
_____
_____

Authorisation for Care of Minor

I hear authorize this center and its Doctor(s) to administer care as they so deem necessary to my son/daughter/ward

_____ _____
Signature Date