NeuroBalance CHIROPRACTIC

Suite 29, 117 Old Pittwater Rd Brookvale, NSW 2100
P 02 9938 5456

E info@neurobalancechiropractic.com.au

1. PERSONAL INFO			DATE:
Name:		DOB:	
Father		Mother:	
Address			
		Postcode:	
Phone:		Mobile:	
Email:			
Blood type (if known)		School & Year	
Siblings: age & sex			
How did you hear about us?	☐ Google ☐ NT Pages ☐ Yahoo ☐ Friend ☐ Other_____		
What modalities interest you?	☐ NES Health ☐ Naturopathy ☐ Nutrition		

2. HEALTH HISTORY			
Are you currently seeing another health/medical practitioner?	☐ yes ☐ no	If yes, name & profession	

Current illnesses/treatment	Medication

Have you had any vaccinations ? If so, what/how many?	
Birth information	Induction drip/gel ☐ Vaginal birth ☐ Caesarean ☐ Forceps/Vacuum ☐ Epidural ☐ Pethidine or other pain relief ☐ Premature ☐ _____
Has your child had any operations or traumas? (Physical/emotional)	

Do you have or have ever experienced any of the following:

☐ Allergies ☐ Sinus/Hayfever ☐ Asthma ☐ Hyperactivity ☐ Eczema/psoriasis

☐ Joint issues ☐ Weight problems ☐ Measles /Mumps / Chicken Pox ☐ Whooping Cough

☐ Developmental delays _____

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3. CURRENT ISSUES
What are health issues or concerns are you interested in addressing? (In order of priority)
1. Please rate severity, 10 = most severe:
2. Out of 10, please rate severity:
3. Out of 10, please rate severity:

4. GENERAL WELLBEING		
Sleep	Hours per night: hour during day:	☐ Night terrors ☐ Nightmares
Mood	Please tick any of the below if ***you feel*** any are a ***problem*** or ***a concern*** *for your child*.	
Tantrums ☐ Anger/outbursts ☐ lack of attention ☐ Hyperactivity ☐ Difficulty relating to others ☐ Anxiety ☐ Depression ☐ Trouble focusing on tasks ☐ Does not respond to verbal cues ☐ Has obsessive or compulsive behaviours ☐		
Does your child play sport? ☐ yes ☐ no If so, what type? _____ Does your child partake in any other extra-curricular activities? ☐ yes ☐ no If so, what type? _____		

5. DIET ANALYSIS - Beverages		
BEVERAGE	DAILY QTY	TYPE (please circle)
Water		Mostly Purified / tap / spring
Soft drink		Type/ brand:
Soft drink/ sports drink/Flav. water		Diet / regular / brand
Juice		Fresh squeezed / bottled Fruit only / mix / vege only

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6. DIET ANALYSIS - DAILY DIET

Please give an example of what a typical day might be. Please provide 2 examples of each meal. This is to show us the 'range' of your diet. For some this might be described as examples of a 'good' day and a 'bad' day.

It is important to provide as much information as possible. Please describe foods consumed, brand names (e.g cereal – Kelloggs cornflakes, bread – Burgen soy linseed), give details on sandwich fillings, sauces, types of grain or pasta (e.g jasmine, calrose or brown rice) & quantities where applicable.

MEAL	TIME	FOOD CONSUMED
Example	7:30am	**Example 1**: 1 tub ski fruit yogurt (lite) strawberry flavour **Example 2:** 2 rashes bacon & 2x eggs – fried on sourdough toast 2pces, w/ butter
Breakfast		**Example 1:** **Example 2:**
Mid-morning		
Lunch		**Example 1:** **Example 2:**
Mid – arvo **Pre-dinner**		
Dinner		**Example 1:** **Example 2:**
Dessert/ **Supper**		