Living Well CHIROPRACTIC Coffs Harbour

HEALTH IN PARTNERSHIP

BABY/TODDLER HISTORY QUESTIONNAIRE

Phone: 02 6651 3901

ACN: 163289405

Child's Name _____

Date of Birth ____/____/____ School/Preschool if attending _____

Address _____

Suburb _____ Post Code _____

Phone (H) _____ (M) _____ (E) _____

Name/s Parent(s) or Guardian(s) _____

Contact phone (if different to above) _____

Siblings names/ages _____

Does the family have a Centrelink health care card? ☐ Yes ☐ No

Doctors Name _____

Has the child seen a chiropractor before? ☐ Yes ☐ No

If yes, name of Chiropractor and date _____

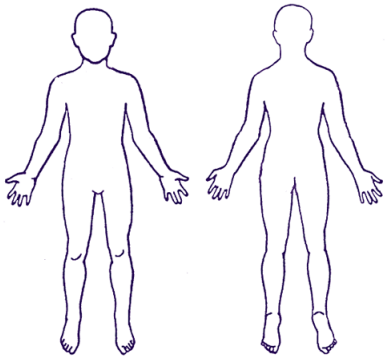
Child's Height (cm) _____Weight (kg) _____

Private health cover _____

Who may we thank for referring you to this Practice

_____

Please use the diagram to indicate any areas of concern on your child's body



What is your main Area of Concern with your child's health?

_____

_____

When did this problem start, date of onset (mm/yyyy)?

_____

The onset was (tick one) ☐ Sudden ☐ Gradual ☐ Associated with an event

Do you know what caused the problem? _____

What makes it better? _____

What makes it worse? _____

Duration of problem/episode e.g. minutes/hours/days_____

Have you had any previous treatment for this problem? ☐ Yes ☐ No

Did it work? _____

How does the problem affect your child's body function and daily activities? _____

_____

Any prior occurrences or episodes? _____

Other health concerns? _____

Birth History

Hospital/Birthing Centre: ☐ Home ☐ Medical ☐ Midwife

Duration of Gestation: _____ weeks

Was the birth assisted? ☐ Yes ☐ No

If Yes how? ☐ Forceps ☐ Vacuum Extraction ☐ Caesarean ☐ Inducted Labour

Were medications given to the mother during labour? ☐ Yes ☐ No

If yes what? _____

Length of labour: _____

Was the delivery normal? ☐ Yes ☐ No

If no, what complications occurred? _____

APGAR'S _____ Birth Weight _____ Birth Length _____

Growth and Development

Was your child alert and responsive within 12 hours of delivery? ☐ Yes ☐ No

If no, explain: _____

Did your child have any problems meeting their developmental milestones? ☐ Yes ☐ No

If yes, explain: _____

At what age did your child crawl? _____ Walk? _____

Does your child have any concerns with vision, hearing or communication: ☐ Yes ☐ No

If yes, explain: _____

Do his/her sleep patterns seem normal? ☐ Yes ☐ No

Does /did your baby have reflux, colic, difficulty gaining weight, or difficulty in settling? ☐ Yes ☐ No

If yes, describe: _____

Describe any health problems that run in the family:

Mum's side _____

Dad's side _____

Siblings _____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

Chemical Stressors

During pregnancy, did the mother:

Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Take supplements/vitamins ☐ Yes ☐ No If yes, what _____

Take drugs ☐ Yes ☐ No If yes, what _____

Become ill ☐ Yes ☐ No If yes, give details _____

Was your child breast fed? ☐ Yes ☐ No For how long_____

At what age was?

Formula introduced:_____ Brand: _____

Cow's Milk: _____ Solid Foods:_____

Is your child fully vaccinated? ☐ Yes ☐ No

Did your child react to them? ☐ Yes ☐ No

Has your child had antibiotics or other medications? ☐ Yes ☐ No

If yes, why? _____

How many courses? _____

Any smokers at home? ☐ Yes ☐ No

Psychological Stressors

Any difficulties with lactation? ☐ Yes ☐ No

Any problems bonding? ☐ Yes ☐ No

Does the child have any behavioural issues that concern you? ☐ Yes ☐ No

If yes what? _____

Does your child have difficulties sleeping? (e.g. night terrors, sleepwalking)? ☐ Yes ☐ No

Physical Stressors

Any evidence of the following trauma during birth (tick):

☐ Bruises ☐ Odd shaped head

☐ Stuck in birth canal ☐ Fast/excessively long birth

☐ Trouble breathing ☐ Cord around neck

Other: _____

Any falls/accidents during pregnancy? ☐ Yes ☐ No

Has the child had any major falls since birth ☐ Yes ☐ No

If yes, was there a fracture or stitches required? Please describe:_____

_____

Has there been any hospitalisation? ☐ Yes ☐ No

If yes, please give date, age and illness/ injury:_____

What is the weight of their school back pack? _____kgs

How many hours per day would your child have screen time (computer games, TV, ipads)? _____

Please TICK the boxes if your child has ever experienced, or is experiencing, the following:

☐ Headaches	☐ Visual Disorders	☐ Recurrent tonsillitis
☐ Neck pain	☐ Learning Difficulties	☐ Recurrent chest infections
☐ Back pain	☐ Digestive Disorders	☐ Recurrent stomach aches
☐ Sinus pain	☐ Asthma	☐ Hyperactivity
☐ Growing pains	☐ Chronic Colds	☐ Constant fatigue
☐ Joint pains	☐ Fevers	☐ Poor Co-ordination
☐ Arm/leg pain	☐ Earaches/infections	☐ Scoliosis
☐ Constipation/diarrhoea	☐ Seizures	☐ Bedwetting
☐ Loss of appetite	☐ Allergies	☐ Hip problems
☐ Travel sickness		

All practitioners who adjust the spine are now required to warn of risks pertaining to spinal adjustments. In extremely rare circumstances (less than 1 in 5.85 million Haldeman, et al. Spine vol 24-8 1999) some spinal adjustments of the neck may damage a blood vessel and give rise to stroke like symptoms. Whilst this has never occurred in this practice we are still required to warn. Other very slight risks with care include muscle strains and sprains and disc injuries. With these incidents full recovery is expected. Tests with or without x-rays will be performed to further minimise risk.

"The best evidence indicated that cervical manipulation for neck pain is much safer that the use of medication (non steroidal anti-inflammatory drugs) by as much as a factor of several hundred times" Dabbs and Lauretti JMPT Oct 1995. (Journal of manipulative physical therapies)

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Signed by the Parent/Guardian: _____ Date _____/_____/____

Print Name: _____

Chiropractors' signature: _____ Date ____/____/____

Thank you for your time and patience filling out your child's health questionnaire

Office use:

Clinical notes explained…… *B.P……*