Toowoomba Clinic for Spine Related Disorders

Patient History – Child

CONFIDENTIAL

Parent / Guardian of the Child's Details

NAME: Dr /Mr /Mrs /Ms .....

Address .....

Home Phone ..... **Work Phone** .....

Mobile Phone..... **Email** .....

Partner's Full Name.....

Emergency Contact Person.....

Phone..... **Relationship to child** .....

Do both parents/guardians consent to chiropractic treatment/examination of the child? **Yes / No**

Child's regular General Practitioner & Location .....

Child's Paediatrician?.....

Our Practice specializes in treating problems of the spine and associated disorders of the nervous system. A proportion of our patients come via referral from their medical practitioner. Therefore, it is standard practice to correspond with your medical practitioner where appropriate

I GIVE / DO NOT GIVE consent for my child's clinical information to be communicated to my General Practitioner where appropriate.

The highest compliment we can be paid is the referral of a friend or loved one. Who may we thank for referring you?.....

Have you seen a Chiropractor before?

Yes If yes, how would you rate the care you received? **Good Fair Poor**

Date of last chiropractic treatment __/__/__ Name of Chiropractor .....

Reason for treatment.....

Did this Chiropractor have Post Graduate Paediatric Chiropractic qualifications? Y**es / No**

No Then don't worry! We will explain everything as we go and only proceed when you are completely comfortable.

Health Fund Name .....

Are you covered for chiropractic care by your health fund? **Yes / No**

Please complete the information on the following pages as accurately as possible as it will help us to evaluate your child's spinal and neurological function, so that we can provide the best possible care.

1. **Name of Child** .....
2. **Child's Date of Birth** ___ ___ / ___ ___ / ___ ___
3. Child's age ___ ___ years___ ___ months
4. Child's sex M / F
5. Birthplace .....
6. Name of Hospital .....
7. **Child's Siblings** *(please list oldest first)*

Name	Age Years & Months	Sex M / F	Relationship to this child Full Half Adopted Step
.....			
.....			
.....			
.....			
.....			

1. The Presenting Complaint:

Presenting complaint .....

Location of symptoms .....

When did the complaint first begin? .....

Was there any trauma / illness / or emotional stress before the onset of symptoms? .....

How frequently do symptoms occur? .....

Are the symptoms worse at a particular time of day? .....

What aggravates the symptoms? .....

What relieves the symptoms? .....

How severe are the symptoms? (1-10 – 10/10 being the worst) .....

Describe the symptoms, eg sharp pain / dull pain / ache etc .....

Has there been any previous treatment? Please describe .....

2. Maternal and Prenatal history:

How was the mother's general state of health during pregnancy? .....

During the pregnancy, did the mother experience?

1. Pre-eclampsia / High blood pressure Yes No .....
2. Gestational diabetes Yes No .....
3. Significant stress Yes No .....
4. Illness or infection Yes No .....

During the pregnancy did the mother use

1. Alcohol (amount per week) Yes No .....
2. Medications - please list Yes No .....
3. Recreational drugs Yes No .....
4. Cigarettes (number per day) Yes No .....
5. Coffee / caffeine (amount) Yes No .....

Was an ultrasound performed during pregnancy Yes No .....

Were the baby's movements normal increased decreased

Were there any previous pregnancies? .....

3. Perinatal history:

Length of gestation. eg Term /37 weeks or Full Term / 39 weeks .....
Total length of Labour .....
Length of hard Labour- "push" time, (from breaking of waters to delivery) .....
Labour room medications. Syntocinon, gas, prostaglandin gel, epidural, pethidine, other .....
.....
Foetal presentation? **Normal / breech / anterior / posterior** .....
Induction? **Yes / No** Please describe .....
Extraction techniques- vacuum, forceps .....
Caesarian section - elective / emergency .....
Do you believe that the delivery was traumatic for your child .....Yes / No
Was your child's head misshapen at birth .....Yes / No
Were there any other complications .....
Apgar Scores at 1 and 5 minutes? ...../..... & ..... / .....
Foetal anthropometry - Head circumference ..... cm - Length..... cm - Weight .....g

4. Neonatal history:

Was the newborn's colour normal? Yes No .....
Was oxygen required / resuscitation required at delivery? Yes No .....
Were there any concerns about the newborn's heart rate? Yes No .....
How soon post birth did bonding with mother occur? .....
How soon post birth did breastfeeding occur? .....
Bowel function - how soon post birth was the 1st bowel movement (meconium)? .....
How soon following birth did the baby cry? .....
Was crying in the first 6 weeks: high-pitched / weak and feeble / normal / hoarse .....
Was there any jaundice in the first few days? Yes No .....
Was photo therapy required (light therapy)? Yes No .....
Was the newborn exhibiting spontaneous equal movements of limbs? Yes No .....
Did the newborn have any tremors? Yes No .....
What were the newborn's sleep characteristics/ patterns over the 1st 6 weeks? .....
.....
What are the current sleep patterns? .....
What are the current feeding patterns? .....
Is the child breast fed / bottle fed / solids? .....
.....
Do you routine feed / feed on demand / combination of both? .....
How many wet nappies per day? .....
How many dirty nappies per day? .....

5. Medical history:

Please tick if your child has ever experienced any of the following:	Yes	No
More than two episodes of otitis media (ear infections)	___	___
Recurrent chest infections	___	___
Recurrent tonsillitis.....	___	___
Sinus pain	___	___
Chronic colds	___	___
Allergies.....	___	___
Asthma	___	___
Visual difficulty requiring either glasses or visual training.....	___	___
Hearing difficulty requiring the use of a hearing aid	___	___

Movement problems requiring the use of special shoes, splints, braces, or a

5. Medical history (continued…)

	Yes	No
Wheelchair or a specialised programme of motor training	___	___
Failure to thrive	___	___
Poisoning, or drug overdose	___	___
Loss of appetite	___	___
Digestive disorders	___	___
Recurrent stomach aches	___	___
Constipation/ Diarrhoea	___	___
Eating unusual substances (eg paint, plaster)	___	___
Unconscious spells, fainting	___	___
Convulsions, seizures, epilepsy	___	___
Bedwetting beyond the age of 5 years	___	___
Soiling beyond the age of 3 years	___	___
Sleeping problems	___	___
Night terrors	___	___
Constant fatigue	___	___
Poor growth, or weight gain	___	___
Unusual reactions to baby vaccinations	___	___
Toe walking	___	___
Poor coordination	___	___
Runs or walks more awkwardly than other children	___	___
Runs or walks more slowly than other children	___	___
Picked last, or close to last, in games where children pick sides	___	___
Tics or unusual movements	___	___
Headaches not relieved by non-prescription pain medicine	___	___
Headaches not relieved by prescription pain medicine	___	___
Headaches occurring in the middle of the night, or upon awakening	___	___
Unusual habits	___	___
Difficulty swallowing	___	___
Excessive drooling	___	___
Poor sucking, or feeding as an infant	___	___
Lost once-attained skills (speech, language, or motor skills)	___	___
Seems to be in a world of his / her own	___	___
Has difficulty with taking turns	___	___
Becomes upset if lined-up toys are disturbed	___	___
Had any fractures / sprains / dislocations	___	___
Scoliosis	___	___
Been involved in a car accident	___	___
Had any significant falls	___	___
Has your child ever been diagnosed as any of the following?		
Hyperactive (hyperkinetic)	___	___
Brain damaged	___	___
Retarded	___	___
Developmentally delayed, or disabled	___	___
Having epileptic seizures (including febrile)	___	___
Motor delayed	___	___
Cerebral palsied	___	___
Language delayed	___	___
Immature	___	___
Hearing impaired, or deaf	___	___
Blind or partially sighted	___	___
Emotionally disturbed	___	___
Hypotonic	___	___
Spasticity	___	___

Attention Deficit Disordered ..... ___ ___
Learning disabled..... ___ ___
Autistic, or demonstrating autistic-like behaviour ..... ___ ___

6. Medication schedule:

Is the child on any medications? Please list .....
How many times has your child taken anti-biotics? In last 6 months ..... in lifetime .....
How many doses of other medication has your child taken? In last 6 months ..... in lifetime .....
Is your child taking any mineral / vitamin / herbal supplements? Please list .....
.....
Has your child had any diseases / illnesses? .....
Has your child had any hospitalisation / surgery?.....

7. Family history:

Is there a family history of genetic diseases? Please list .....
Was the rate of development of siblings normal? .....
Is there a family history of a similar complaint as this child has? Parents / siblings.....

8. Development history:

Has your child displayed any delay in development of any of the following?

1. Language acquisition .....
2. Hearing .....
3. Fine motor skills.....
4. Gross motor skills.....
5. Social skills .....

Did your child exhibit any of the following in the first year of life?

1. Spastic, or jerky movements.....
2. Assumption of fixed postures .....
3. Decreased movements on one side of body .....
4. Persistent fisting with thumb under curled fingers .....
5. Scissoring of the legs when held upright.....
6. Low muscle tone .....
7. Muscle tremors .....
8. Seizures .....

How old was your baby (your best guess, in months) when he / she first

	4-6	**6-9**	**9-11**	**11-13**	**13-18**	**18-24**	**24-36**
1. Rolled back to front	____	____	____	____	____	____	___
2. Commando crawled	____	____	____	____	____	____	___
3 Crept (crawl-hands/ knees)	____	____	____	____	____	____	___
4 Sat alone	____	____	____	____	____	____	___
5. Stand alone	____	____	____	____	____	____	___
6. Cruised (walk holding couch)	____	____	____	____	____	____	___
7. Walked with assistance	____	____	____	____	____	____	___
8. Walked without assistance	____	____	____	____	____	____	___
9. Showed hand preference	____	____	____	____	____	____	___
10. Was toilet trained – bowel	____	____	____	____	____	____	___
11. Was toilet trained – urine	____	____	____	____	____	____	___
12. Began to vocalise (babble)	____	____	____	____	____	____	___
13. Began to use words	____	____	____	____	____	____	___
14. Began to talk in sentences	____	____	____	____	____	____	___

9. Review of systems - Does your child have any problems in the following areas of the body?

1. Head and neck (eg skin marks, lumps, asymmetry etc).....
2. Skin / hair / nails.....

3. Breasts.....
4. Respiratory problems (eg shortness of breath, wheezes, cough) .....
5. Cardiovascular problems (heart problems - easily fatigued, blue lips / hands etc) .....
6. Gastrointestinal problems (digestive problems - reflux, colic, constipation etc).....
7. Genitourinary problems (bladder infections, bed wetting, frequency etc) .....
8. Neuro-musculoskeletal problems (poor coordination etc).....
9. Psychological problems .....
10. Endocrine / hormonal problems (low energy levels, thyroid problems, adrenal problems, etc) .
.....

10. Diet: If your child is eating solids, how many of the following per day are consumed?

1. Fruit ..... _____
2. Cups of vegetables ..... _____
3. Milliliters of water..... _____
4. Other drinks (milk, soft drink, juice etc)..... _____
5. Grains (cereals, bread, cake, pasta, rice)..... _____
6. Dairy ..... _____
7. Soy ..... _____
8. Foods that contain, colours, preservatives ..... _____
9. Sugar..... _____
10. Meat ..... _____
11. Does your child eat organic food regularly?.. _____
12. Nuts ..... _____
13. Eggs..... _____
14. Omega 3..... _____
15. Vitamin D ..... _____
16. Probiotic ..... _____

11. Physical support: Does the following apply to your child? *(Please tick)*

	Yes	**No**
1. Sleeps on a mattress that is over 5 years old	___	___
2. Wake up sore, stiff, or cranky?	___	___
3. Sleep with a pillow? Has the pillow been fitted by a chiropractor?	__	___
4. Is the pillow contour in shape?.....	___	___
5. Engage in daily physical play? (Run, jump, bike, climb etc)	___	___
6. Play sport? If so which sports?.....	___	___
7. Been in a car accident? Was there an injury?	___	___
8. Broken a bone, if so where and when?	___	___
9. Sprained a joint? Where and when?.....	___	___
10. Been involved in domestic violence?.....	___	___
11. Wear orthotics in shoes.....	___	___

12. Emotional support: Does your child display any of the following on a regular basis?

	Yes	**No**
1. Joy and happiness	___	___
2. Displays of affection (cuddles, kisses etc)	___	___
3. Anxiety/ Depression	___	___
5. Pessimism	___	___
6. Crying	___	___
7. Tantrums	___	___
8. Bullying / Aggression.....	___	___
9. Needed psychological or counselor support?	___	___