Welcome to the Toowoomba Clinic for Spine Related Disorders

Personal Details

CONFIDENTIAL

Parent/ Guardian of child

NAME: Dr /Mr /Mrs /Ms _____

ADDRESS: _____

_____ POSTCODE: _____

PHONE HOME: _____ PHONE WORK: _____

MOBILE PHONE: _____EMAIL: _____

BIRTHDATE: _____OCCUPATION: _____

PARTNER'S NAME: _____NO. OF CHILDREN: _____

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

Who is your regular (General Practitioner)? _____
Who is your regular Pediatrician? _____

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. As such, 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 ever 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 qualifications Yes No

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

What Health fund do you belong to? _____

Are you covered for chiropractic care (we need to know this as some health funds require specific item numbers)? _____

Please complete the information on the following pages as accurately as possible, as it will help us in evaluating 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 ___ ___ / ___ ___
4. Child's sex M / F
5. Birthplace _____
6. Name of hospital _____
7. Child's siblings *(please list oldest first)*:

	Age		Sex		Relation to this child			
Name	Years	Months	M	F	Full	Half	Adopted	Step

1. The presenting complaint:

Presenting complaint?_____
Location of symptoms?_____
When did complaint first begin?_____
Was there any trauma/ illness/ or emotional stress before 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? (out of 10 - 10 being the worst)_____
Can you describe the symptoms? eg. sharp pain/ dull ache/ etc_____
Has there been any previous treatment? please describe._____

2. Maternal and Prenatal history:

How was the mothers 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/ 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 (amount 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 / 38 weeks _____
Total length of labour?_____Length of hard labour- "push"?_____time from breaking of waters to delivery_____
Labour room medications? Syntocin, gas, prostaglandin gel, epidural, pethidine, other _____
Foetal presentation? Ie normal breech anterior posterior _____
Induction? Yes/ No describe_____
Extraction techniques- vacuum, forceps? _____

Caeserian section- elective/emergency? _____
Do you believe that the delivery was traumatic for your child? Yes/ No
Was your child's head mis-shapen 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/ week 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 wheelchair or a specialized programme of motor training	___	___
Failure to thrive	___	___
Poisoning or drug overdose	___	___
Loss of appetite	___	___
Digestive disorders	___	___
Recurrent stomach aches	___	___
Constipation/ Diarrhoea	___	___
Eating unusual substances (e.g., paint, plaster)	___	___
Unconscious spells, fainting	___	___
Convulsions, seizures, epilepsy	___	___
Bedwetting beyond the age of 5 years	___	___
Soiling beyond the age of 3 years	___	___
Sleeping problems	___	___

	Yes	No
Night terrors	___	___
Constant fatigue	___	___
Poor growth or weight gain	___	___
Unusual reactions to baby shots/vaccinations	___	___
Toe walking	___	___
Poor coordination	___	___
Run or walk more awkwardly than other children	___	___
Run or walk 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 nonprescription 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)	___	___
Seemed to be in a world of his own	___	___
Had difficulty with taking turns	___	___
Became upset if lined-up toys were disturbed	___	___
Had any fractures/ sprains/ dislocations	___	___
Scoliosis	___	___
Been involved in a car accident	___	___
Had any significant falls	___	___

Has your child ever been diagnosed as:

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	___	___
Spastic	___	___
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 ____lifetime_____

Is the child taking any mineral/ vitamin/ herbal supplements? Please list

_____

Has your child had any diseases/ illnesses? _____

Has your child had any hospitalization/ 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? Parents/ siblings _____

_____

8. Development history:

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

1. language acquisition _____
2. hearing _____
3. fine motor skills _____
4. gross motor skills _____
5. social skills _____

Does 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

	Under	6-12	12-18	18-24	24-36	36-48	48+
a. Sat alone	____	____	____	____	____	____	___
b. Crawled	____	____	____	____	____	____	___
c. Stood alone	____	____	____	____	____	____	___
d. Walked with assistance	____	____	____	____	____	____	___
e. Walked without assistance	____	____	____	____	____	____	___
f. Showed hand preference	____	____	____	____	____	____	___
g. Was toilet trained – bowel	____	____	____	____	____	____	___
h. Was toilet trained – urine	____	____	____	____	____	____	___
i. Began to vocalize (babble)	____	____	____	____	____	____	___
j. Began to use words	____	____	____	____	____	____	___
k. 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. neuromusculoskeletal 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. Millilitres 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? _____

11. Physical support; Does your child (please circle)

1. Sleep on a mattress that is over 5 years old?	Yes	No
2. Is the mattress of good quality?	Yes	No
3. Wake up sore, stiff or cranky?	Yes	No
4. Sleep with a pillow?	Yes	No
5. Has the pillow been fitted by a chiropractor?	Yes	No
6. Is the pillow contour in shape?	Yes	No
7. Have allergies, asthma, or eczema?	Yes	No
8. Quality water proof protectors on the mattress and pillow?	Yes	No
9. Regularly wet the bed?	Yes	No
10. Engage in daily physical play? (Run, jump, bike, climb etc)	Yes	No
11. Play sport? If so what sports? _____		
12. Been in a car accident? Was there an injury? _____	Yes	No
13. Broken a bone, if so where and when? _____	Yes	No
14. Sprained a joint? Where and when? _____	Yes	No
15. Been involved in domestic violence?	Yes	No
16. Wear good quality shoes?	Yes	No
17. Wear orthotics in shoes?	Yes	No

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

1. Joy and happiness	Yes	No
2. Displays of affection (cuddles, kisses etc)	Yes	No
3. Anxiety	Yes	No
4. Depression	Yes	No
5. Pessimism	Yes	No
6. Crying	Yes	No
7. Tantrums	Yes	No
8. Bullying?	Yes	No
9. Aggression?	Yes	No
10. Difficult sleep?	Yes	No
11. Anger?	Yes	No
12. needed psychological or counselor support	Yes	No

Thank you for your patience in completing this form. The more information we have when assessing your child, the more we may be able to help. The chiropractor will review the information and then begin a thorough examination of your child. No treatment will be rendered. If treatment is required you will be advised of this and appointment will be made at a later date.