Advanced Paediatric Patient History Form

Aberdeen Chiropractic Clinic
your health & well being since 1979

Date: Practitioner: Service Type: Patient ID:

Confidential Patient Information

The Advanced Paediatric Case History Form is used for children with chronic medical and/or developmental concerns. If the assessment is for a general check - up, muscular, skeletal or neurological concerns, or a post delivery check, please complete the Paediatric Patient History Form.

Name: _____ Age: _____ Date of Birth: _____

Address: _____ Town: _____ Postcode: _____

Tel. (Home): _____

Name of GP, Surgery, Health Visitor: _____

Mother's Name: _____ Date of Birth: _____ Mobile: _____

Father's Name: _____ Date of Birth: _____ Mobile: _____

Contact Email: _____

Male/Female: _____ No of Siblings: _____ Referred/recommended by: _____

How did you hear about us? (e.g. friend / family / internet / event / location?) _____

Are you here because of corporate agreement? (If yes which company?) _____

Are you covered by private medical insurance? (If yes which company?) _____

FAMILY SETUP				
Health of Mother:	☐ GOOD	☐ MODERATE	☐ POOR	Age of mother at birth of affected child
Give details:				
Health of Father:	☐ GOOD	☐ MODERATE	☐ POOR	Age of father at birth of affected child
Give details:				
Brief family history parents/grandparents - any known illnesses or development concerns?				
Occupation of mother pre and during pregnancy:				
Occupation of father pre and during pregnancy:				

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PREGNANCY	DETAILS
Trauma, e.g. RTA, falls	
Mental stress, e.g. divorce, death etc.	
Diabetes	
Anaemia	
Bleeding	
Hypertension	
Protein in the urine	
Convulsions	
Liver complaints	
Kidney complaints	
Mother's diet, during pregnancy	☐ Unrestricted ☐ Vegetarian ☐ Vegan Other
Alcohol consumption during pregnancy	☐ Yes ☐ No Units a day:
Any medication (prescribed, recreational or over the counter) during pregnancy:	What: When:
Any vitamins taken or supplements:	What When:
Determine caffeine intake, coffee, tea, chocolate: (e.g. cups/bars per day)	
Did the mother smoke during pregnancy?	☐ Yes ☐ No How many a day:
Did the father smoke during pregnancy?	☐ Yes ☐ No How many a day:
Was the conception natural?	☐ Yes ☐ No
How many X-rays or Ultra-sound scans during and before pregnancy? When?	
Does either parent have any allergies?	☐ Yes ☐ No If yes what?
The baby/babies 3rd trimester presentation:	

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THE BIRTH AND FIRST DAYS OF YOUR BABY/BABIES LIFE				
How would you consider the birth experience:				
What week gestational was your child born?				
Where was the child born?	☐ Hospital	☐ Home	☐ Midwife Unit	Other:
How did the birth start?	☐ Spontaneous	☐ Induced		
Were any drugs employed during the birth?	☐ Gas & Air	☐ Pethidine	☐ Epidural	Other:
Position of mother during birth:				
Length of 1st stage of labour:	Length of 2nd stage/how many pushes:			
Length of 3rd stage/placental delivery:		When was the cord clamped?		
Was placenta normal size and weight?	☐ Yes	☐ No		
Was the delivery assisted?	☐ Natural	☐ Forceps	☐ Ventouse	☐ Kiwi
If assisted: - type and placement				
If caesarean	☐ Emergency	☐ Elective		
Were there any complications? Details:				
Any fetal distress?	☐ Yes	☐ No	Details:	
Did the child suffer?	☐ Fractures	☐ Jaundice	☐ Cyanosis	
Birth Details	Head circumference cm:	Length cm:	APGAR score:	
Did the baby latch in the first hour after birth?	☐ Yes	☐ No	Details:	
Was baby breastfed?	☐ Yes	☐ No	for how long:	What formula:
Were there any problems breast feeding?				
When were solids introduced?				
What were first solids and how was it?				
Did your child suffer from:	Colic ☐	Vomiting reflux ☐	Bowel problems ☐	

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SPEECH AND LATER DEVELOPMENT

Has your baby been diagnosed with a speech problem?	
If yes: When? and has your child received speech therapy?	

Dry by day:	When	Not yet
Dry by night:	When	Not yet
Any accidents since/regression?		Any aspects of soiling:

Nursery/Pre-school: ☐ Socializing ☐ Aggression ☐ Imaginative Play
✓ = Good ✕ = Not Good

Primary and Secondary School: ☐ Handwriting/grip ☐ Colouring-in ☐ Concentration
✓ = Good ✕ = Not Good ☐ Reading ☐ Spelling ☐ Maths

(DELETE APPROPRIATE ...) Handed: R / L Footed: R / L Eyed: R / L

Has there been any suspected developmental delay?

If yes, who noticed it first and when was it noticed?

Late riding a bicycle?	☐ Yes	☐ No	Accident prone?	☐ Yes	☐ No
Lack of concentration?	☐ Yes	☐ No	Clumsy?	☐ Yes	☐ No
Problems dressing?	☐ Yes	☐ No	Problems feeding?	☐ Yes	☐ No
Short-term memory?	☐ Poor	☐ Good	Spatial awareness?	☐ Poor	☐ Good

Noise in the ear?

Double or blurred vision?

Decreased sense of smell?

Any rituals or obsessions?

Level of activity?

Tics - involuntary movements, e.g. blinking, grimmacing, grunting? ☐ Yes ☐ No

Toe walking, flapping/spinning, eye contact, affectionate? ☐ Yes ☐ No

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SPEECH AND LATER DEVELOPMENT (continued)

List any issues at school?

Has your child been diagnosed with any developmental condition?

If yes, has there been any previous or ongoing treatment?

CHILDS HISTORY

How is your child's sleep? ☐ Fair ☐ Poor ☐ Good Number of Hours?

Details?

Congenital Anomalies / Defects: ☐ Yes ☐ No If yes please explain:

What is the concern and why have you presented to us with your child?

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CHILDS HISTORY (continued)

Date of last GP or Health Visitor visit:	Reason for visit:
Vaccination History:	
Medication History:	
Antibiotics in the past six months:	During lifetime:
Has your child had a reaction to any medication, vaccine, environmental toxin, supplement or food group?	
Previous Chiropractor:	
Date of last visit:	Reason for visit:
Other practitioners visited for any reason? Please give details?	

At what age did the child:

Respond to sound? _____ Follow an object with eyes? _____ Hold head up? _____

Sit alone? _____ Crawl? _____ Stand? _____ Walk alone? _____

What type of crawl? ☐ Cross-crawl ☐ Buttom Shuffle ☐ Combat-crawl

Has your child ever been treated for an emergency? Yes / No

Did the child suffer from the following childhood diseases? When?

☐ Chickenpox? _____ ☐ Mumps? _____ ☐ Measles? _____ ☐ Rubella? _____

☐ Rubeola? _____ ☐ Whooping cough? _____ Other? _____

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CHILDS HISTORY (continued)

Has the child suffered from:

☐ Headaches	☐ Orthopaedic problems	☐ Digestive disorders	☐ Behavioural problems
☐ Dizziness	☐ Neck problems	☐ Poor appetite	☐ ADD/ADHD/Concentration
☐ Fainting	☐ Arm problems	☐ Stomach aches	☐ Delay development
☐ Seizures/Convulsions	☐ Leg problems	☐ Reflux	☐ Muscle pain
☐ Heart trouble	☐ Joint problems	☐ Constipation	☐ Growing pains
☐ Chronic earaches	☐ Backaches	☐ Diarrhoea	☐ Hyperactivity
☐ Sinus troubles	☐ Poor posture	☐ Diabetes	☐ Ruptures/Hernia
☐ Asthma	☐ Scoliosis	☐ Hypertension	☐ Skin condition
☐ Colds/Flu	☐ Walking trouble	☐ Anaemia	☐ Excessive crying
☐ Colic	☐ Broken bones	☐ Bedwetting	☐ Allergies to:
☐ Eczema	☐ Illnesses or infections	☐ Teeth/Teething/Braces	_____

Has your child suffered any of the following trauma that could affect the spine and nervous systems?

☐ Fall in baby walker	☐ Fall from couch	☐ Fall off skateboard/skates
☐ Fall from cot	☐ Fall off swing	☐ Fall off bicycle
☐ Fall from highchair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off climbing frame	☐ Other:
☐ Bangs/Knocks esp. head	☐ Heavy falls	

Has the child ever sustained an injury playing organised sports? ☐ Yes ☐ No

Has the child ever sustained injuries in a car accident? ☐ Yes ☐ No

Surgery/Operations:

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CHILDS HISTORY (continued)
Typical intake of food and drink for 1 day?
Is your child taking homeopathic or classical medication?
Is your child taking any supplements?
Is your child on any special diet?

AUTHORISATION FOR EXAMINATION OF A MINOR

I hereby authorise this clinic and its Doctor (s) to administer an examination as they deem necessary to my child (upon approval of parent or guardian). I realise that I am responsible for all fees charged by this office and I agree to pay for all services provided.

Relationship to child: _____

Signed: _____ Date: _____