0-12 months

Paediatric Health History

Child Name: _____ Child Age: _____ D.O.B: ____/____/____ Gender: M☐ F☐

Parent/Guardian Name(s): _____

Siblings (names and age): _____

Address: _____

Phone: _____ Email: _____

Paediatrician/Dr: _____

Do you have private health cover: Yes / No. If so, which fund? _____

How did you hear about Tamar Chiropractic? _____

Reason for today's visit *(if coming in for a check-up, please leave the following 6 questions blank):*

_____

_____

_____

When did this condition begin? _____

Have there been any change(s) in condition since onset? _____

_____

What makes the condition better? _____

What makes the condition worse? _____

Have there been previous episodes? _____

If other health practitioners have been consulted, please provide details: _____

_____

Is your child currently taking any medication? Yes / No. Please list: _____

_____

Please list any previous medications: _____

Please list medical illnesses/diagnoses: _____

Has your child ever been hospitalised? _____ Has your child ever had surgery? _____

Has your child had any significant falls/accidents/trauma? _____

Please circle whether your child has suffered from any of the following symptoms, whether past or present:

Headache	Sinus troubles	Scoliosis	Colic
Ear ache/infections	Tonsillitis	Reflux	Constipation/Diarrhoea
Hip problems	Asthma/chronic cough	Frequent colds & flu's	Digestive disorders
Developmental delay	Preferred head position	Back arching	Poor sleeping habits
Migraine	Poor coordination	Motion sickness	Allergies

Other:

_____

_____

Pregnancy

Mothers age: _____ Conception: Natural / Assisted _____

Were there any complications experienced during the pregnancy? _____

During the pregnancy, did mum suffer any illnesses or trauma? _____

Please list any medications and supplements taken: _____

Smoker? Yes / No Alcohol use during pregnancy? Yes / No

Birth

Gestational age: _____ Birth weight: _____kg Birth length: _____cm

Birth location (please circle): Home / Birthing Centre / Hospital / Other _____

Duration of birth? _____ How long did mum 'push' for? _____

APGAR score: Birth _____ After 5 mins _____

Was baby born via c-section? Yes / No If yes, was it planned or an emergency? _____

_____

Please circle if any of the following were used during the birth process:

Medications Epidural Vacuum/suction Episiotomy Induction Gas Forceps

Was baby born: Cephalic (head first): Yes / No Breech: Yes / No Posterior: Yes / No

Was baby born with any noticeable marks / bruising / misshapen head / cord around neck?

Is there anything else you would like to share about the birth of your child? _____

_____

Nutrition

Is child breast or bottle fed? _____ For how long was child breastfed? _____

If breastfed, are there any concerns or issues? _____

At what age were solid foods introduced? _____

What foods does your child eat? _____

Does your child have any known food intolerances or allergies? _____

Development

At what age did your child.....

Hold head up? _____ Roll? _____ Sit by self? _____

Walk? _____ Crawl? _____ Crawl type? _____

Babble/talk? _____ Respond to sound? _____ Develop a side of dominance? _____

CANCELLATION POLICY

Tamar Chiropractic & Allied Health is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us by 5pm the business day prior to your scheduled appointment to notify us of any changes. Failure to do so incurs a fee equal to that of the booked appointment.

Print Parent Name: _____

Signature: _____ Date:_____