LANE COVE CHIROPRACTIC

9428 4033
Unit 1/46 Burns Bay Rd,
Lane Cove, NSW, 2066

CHILD HISTORY QUESTIONNAIRE

Today's Date: ____ /____ /____

WELCOME TO OUR PRACTICE

Child's Name _____

Date of Birth ____ /____ /____ Phone: _____

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

Home Address _____

Suburb _____ Post Code _____

Email Address _____

Doctor's Name _____ Dr Address _____

Previous Chiropractor Name _____

Date of Last Visit ____ /____ /____

Child's Height: _____ cm Child's Weight: _____ kg

Who may we thank for referring you to this practice? _____

HOW CAN WE HELP YOU

What are your chief concerns, if any, with your child's health?

_____

_____

List any other care that your child has undergone with regards to this complaint, including medication:

_____

Date of onset: ____ /____ /____

The onset was: ◯ Sudden ◯ Gradual ◯ Associated with an event

Duration of problem/episode: ◯ Minutes ◯ Hours ◯ Days ◯ Months ◯ Years

Initiating Factors: _____

Aggravating Factors: _____

Relieving Factors: _____

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

_____

_____

Prior occurrence or episodes? _____

Other health concerns?

_____

_____

HISTORY OF BIRTH

Hospital/Birthing Centre: ◯ Home ◯ Medical ◯ Midwife

Duration of Gestation: _____ Weeks

Was the birth vaginal? ◯ Yes ◯ No Duration of birth: _____

Was the birth assisted? ◯ Yes ◯ No

If yes, how? ◯ Forceps ◯ Vacuum ◯ Caesarean ◯ Induced Labour

Were medications given to the mother at birth? ◯ Yes ◯ No

If yes, what? _____

Were there any complications during birth? _____

APGARs: _____ Birth Weight: _____ Birth Length: _____

GROWTH & DEVELOPMENT

Was the infant alert and responsive within 12hrs of the delivery? ◯ Yes ◯ No

If no, explain: _____

At what age did the child:

Respond to sound _____ Crawl _____

Hold up head _____ Vocalize _____

Follow an object _____ Teethe _____

Sit alone _____ Walk _____

Do the child's sleeping patterns seem normal? ◯ Yes ◯ No

Any health problems on the mother's/father's side of the family? e.g. cancer, diabetes

_____

_____

Does the child's siblings have any health problems? ◯ Yes ◯ No

If yes, describe: _____

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

CHEMICAL STRESSORS

During the pregnancy, did the mother:

Smoke ◯ Yes ◯ No Drink alcohol ◯ Yes ◯ No

Take supplements/vitamins ◯ Yes ◯ No Take drugs ◯ Yes ◯ No

If yes, what? _____

Become ill ◯ Yes ◯ No If yes, what? _____

Receive ultrasounds ◯ Yes ◯ No If yes, how many? _____

Receive invasive procedures ◯ Yes ◯ No *i.e amniocentesis, CVS*

Was your child breast fed? ◯ Yes ◯ No For how long? _____

At what age was: Formula introduced: _____ Brand: _____

Cow's milk: _____ Solid Foods: _____

Did your child receive vaccinations? ◯ Yes ◯ No

If yes, which ones? _____

Did your child react to them? ◯ Yes ◯ No

Has your child had antibiotics? ◯ Yes ◯ No

If yes, why? _____

How many courses? _____

Any pets at home? ◯ Yes ◯ No Any smokers at home? ◯ Yes ◯ No

PSYCHOLOGICAL STRESSORS

Any difficulties with lactation? ◯ Yes ◯ No

Any problems with bonding? ◯ Yes ◯ No

Does your child have difficulty self regulating? ◯ Yes ◯ No

If yes, what? _____

Does your child have difficulties sleeping? e.g. night terrors, sleep walking ◯ Yes ◯ No

Did your child go to daycare? ◯ Yes ◯ No

If yes, from what age? _____

Average number of hours of TV/Computer per week? _____ Hours

TRAUMATIC STRESSORS

Did any of the following occur during or after birth? (please tick):

Bruises ◯ Odd shaped head ◯

Stuck in birth canal ◯ Fast/excessively long birth ◯

Respiratory Depression ◯ Cord around neck ◯

Other: _____

Any falls/accidents during pregnancy? ◯ Yes ◯ No

Has the child had any major falls since birth? ◯ Yes ◯ No

If yes, did the child need stitches or cause a fracture? Please describe:

_____

Any hospitalisations? ◯ Yes ◯ No If yes, please explain: _____

Does your child play sports? ◯ Yes ◯ No

If yes, how many hours per week? _____ Age child began: _____

Weight of school backpack? _____ kg

Approximately how many hours does your child spend at play per week? _____ hours

TICK THE BOXES BELOW IF YOUR CHILD HAS EVER EXPERIENCED/IS EXPERIENCING THE FOLLOWING

- ◯ Constipation/ Diarrhoea
- ◯ Loss of Appetite
- ◯ Travel Sickness
- ◯ Visual Disorders
- ◯ Learning Difficulties
- ◯ Digestive Disorders
- ◯ Hip Problems
- ◯ Headaches
- ◯ Neck Pain
- ◯ Back Pain
- ◯ Sinus Pain
- ◯ Growing Pain
- ◯ Joint Pain
- ◯ Arm/Leg Pain
- ◯ Earaches/ Infections
- ◯ Recurrent Tonsillitis
- ◯ Recurrent Chest Infection
- ◯ Recurrent Stomach Aches
- ◯ Poor Co-ordination
- ◯ Constant Fatigue
- ◯ Scoliosis
- ◯ Seizures
- ◯ Allergies
- ◯ Asthma
- ◯ Chronic Colds
- ◯ Fevers
- ◯ Hyperactivity
- ◯ Bed Wetting

PATIENT INFORMATION & INFORMED CONSENT

All practitioners who adjust the spine are now required to warn of material risks pertaining to spinal adjustments. In extremely rare circumstances (less that 1 in 2 million) 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 disk injuries. With these incidents full recovery is expected. Test with or without x-rays will be performed to further minimise risk.

"The best evidence indicates that cervical manipulation for neck pain is much safer than 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.

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

Parent/Guardian Signature: _____

Print Name: _____

Chiropractor's Signature: _____ Date: ____ /____ /____