Adelaide Chiropractic Centre

Level 3, 55 Gawler Place, Adelaide, South Australia 5000
Telephone (08) 8221 6262

Dr Tamara N. Swaffer B.Sc. M. Chiropractic
Dr Nicola Ross B.SC. M.Chiropractic

Paediatric Health History

Child's Name: .... **Date:** .... **Patient Number:** ....

Parent Names: .... **Siblings' Names & Ages:** ....
....

Child's Age: .... Birth Date: .... *(dd/mm/yy)* Sex: M F

Address: ....

Home Phone: .... Other Number: ....

Family doctor's name: .... Address: ....

Who may we thank for referring you? ....

Has your child ever received chiropractic care? YES ☐ NO ☐

If yes, who is your child's previous Doctor of Chiropractic?: ....

The date of last visit: ....

Other professionals seen for this condition: ....

Results with that treatment? ....

Recent tests done *(list date beside)*:

☐ Blood work .... ☐ Urine .... ☐ X-Rays ....

Other: *explain* ....

Please tick the purpose for your child's visit:

- ☐ crisis management
- ☐ early detection of problems
- ☐ prevention
- ☐ wellness
- ☐ maximising normal growth & development
- ☐ other

Authorising Consent for examination of a Minor (under 18 years): Please Read Carefully
In order for the health professional as indicated below to make a determination on the suitability of my child's/ guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorised to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorised to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child's interests.

Name: .... Date: ....

Signature: .... Witness: ....

Doctor of Chiropractic: ....

Address: ....

Present Health Concerns

Major ....

Minor ....

When did this problem begin? ....

Is this problem: occasional ❑ frequent ❑ constant ❑ intermittent ❑

Does problem radiate? YES ❑ NO ❑ *If Yes, where?* ....

What makes this worse? ....

What makes this better? ....

Is the problem worse during a certain time of the day? YES ❑ NO ❑

If Yes, when? ....

Does this interfere with the child's sleep? YES ❑ NO ❑ Eating? YES ❑ NO ❑

Daily routine? YES ❑ NO ❑

Is this becoming worse? YES ❑ NO ❑

Often seemingly unrelated symptoms can manifest as other health concerns.
Please tick if your child has had any of the following

- ❑ headaches
- ❑ dizziness
- ❑ irritability
- ❑ fatigue
- ❑ depression
- ❑ loss of balance
- ❑ loss of concentration
- ❑ fainting
- ❑ ears buzzing
- ❑ poor coordination
- ❑ vision changes
- ❑ loss of memory
- ❑ loss of smell
- ❑ loss of taste
- ❑ light sensitivity
- ❑ face flushed
- ❑ reduced mobility
- ❑ chest pressure
- ❑ breast pain
- ❑ frequent colds
- ❑ sinus congestion
- ❑ sore throats
- ❑ ear pain/infections
- ❑ asthma
- ❑ cold sweats
- ❑ bronchitis
- ❑ pneumonia
- ❑ difficulty breathing
- ❑ shortness of breath
- ❑ allergies
- ❑ constipation
- ❑ diarrhea
- ❑ urinary problems
- ❑ bloating/gas
- ❑ weight loss
- ❑ weight gain
- ❑ dental problems
- ❑ fevers
- ❑ heart palpitations
- ❑ numbness in feet
- ❑ numbness in hand(s)
- ❑ weakness
- ❑ heartburn
- ❑ muscle cramps
- ❑ upper back pain
- ❑ neck pain
- ❑ low back pain
- ❑ radiating pain
- ❑ sleeping problems
numbness in leg(s)
- ❑ stiffness

❑ Other: ....

Birth History

What was the child's gestational age at birth? .... weeks.

Birth weight .... Birth length ....

Was your child's birth: ❑ at home ❑ in a birthing centre ❑ hospital ❑ other

Was the birth considered: ❑ medical ❑ midwife Duration of birth: .... hours

Was child born: ❑ cephalic *(head first)* ❑ breech *(feet first)*

Were there any complications? YES ❑ NO ❑ If Yes, please explain ....

Assistances used during delivery: ❑ Forceps ❑ Vacuum extraction ❑ C-section ❑ Episiotomy

Was labour: ❑ spontaneous ❑ induced

Were medications or epidurals given to the mother during birth? YES ❑ NO ❑

APGAR score: at Birth .... /10 After 5 minutes .... /10

Is there anything else we need to know about the birth YES ❑ NO ❑

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? YES ❑ NO ❑

If no, please explain ....

At what age did the child: Respond to sound .... Follow and object ....

Hold up head .... Vocalize ....

Sit alone .... Teethe ....

Crawl .... Walk ....

Does your child sleep: ❑ front ❑ back ❑ side

Do you consider the child's sleeping pattern normal? YES ❑ NO ❑

How many hours per day? .... If no, please explain ....

....

....

Family History

Please note any health problems *(ie: cancer, hereditary conditions, diabetes, heart disease)* that are present in:

Mothers family ....

Fathers family ....

Siblings ....

....

....

Physical Stressors

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Any traumas to the mother during pregnancy? *(ie: falls, accidents, etc.)* YES ❑ NO ❑

If yes, please explain ....

....

Any evidence of birth trauma in the infant?

❑ bruising ❑ odd shaped head

❑ stuck in birth canal ❑ fast or excessively long birth

❑ respiratory depression ❑ cord around neck

Any falls from couches, beds, change tables, etc? YES ❑ NO ❑

If yes, please explain ....

Any traumas resulting in bruises, cuts, stitches or fractures? YES ❑ NO ❑

If yes, please explain ....

Any hospitalizations or surgeries? YES ❑ NO ❑

If yes, please explain ....

Any sports played? ....

Is a school backpack used? YES ❑ NO ❑ Is it ❑ heavy or ❑ light

Chemical Stressors

Was this child breast-fed? YES ❑ NO ❑ *If yes, how long:* ....

Formula introduced at what age: .... Which formula? ....

Introduction of cow's milk at what age: .... Began solid foods at what age: ....

Types of solid foods: ....

Food/Juice intolerance? YES ❑ NO ❑ Type: ....

Is your child on or have taken any medications? ....

During the mother's pregnancy:

Did the mother smoke? YES ❑ NO ❑ *How much?* ....

Drink alcohol? YES ❑ NO ❑ *How much?* ....

Any illnesses during the pregnancy? YES ❑ NO ❑ *If yes, describe* ....

Any supplements taken during pregnancy? YES ❑ NO ❑ *If yes, describe* ....

Any drugs taken during pregnancy? YES ❑ NO ❑ *If yes, describe* ....

Any ultrasounds? YES ❑ NO ❑ How many? .... Reasons for being done ....

....

....

Any invasive procedures during pregnancy *(ie: amniocentesis, Chorionic villi sampling, etc)*?

YES ☐ NO ☐ If yes, please explain ....

....

....

Any pets at home YES ☐ NO ☐

Any smokers in the home? YES ☐ NO ☐

Any antibiotics given? YES ☐ NO ☐ *If yes, reason:* ....

Psychosocial Stressors

Any difficulties with lactation? YES ☐ NO ☐

Any problems with bonding? YES ☐ NO ☐

Any behavioral problems? YES ☐ NO ☐

Any inattention? YES ☐ NO ☐

Any hyperactivity or restlessness? YES ☐ NO ☐

Any compulsiveness? YES ☐ NO ☐

Any difficulties at daycare or school? YES ☐ NO ☐

Any challenges with learning deficiencies? YES ☐ NO ☐

Any night terrors, sleep walking, difficulty sleeping? YES ☐ NO ☐

Any prolonged temper tantrums or separation anxiety? YES ☐ NO ☐

Is the child in day care YES ☐ NO ☐

Age of child when began daycare? ....

Average number of hours of television per week? ....

Average number of hours of video games per week? ....

Does your child have a mobile phone? YES ☐ NO ☐

How often do they text or use the phone? ....

Do you feel that your child's social and emotional development is normal for their age?

YES ☐ NO ☐

Thank you for completing this form. If you have anything to add below, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have, please discuss with the doctor.

....

....

....

....

Parent/Guardian

Signature .... *Date* ....