

Paediatric Case History Form (0-6mths)

Name of Child..... D.O.B..... Age.....

Address.....

Contact number....Home..... Mobile.....

Name and ages of siblings.....

Mum's name..... Dad's name.....

It is a legal requirement that both parents/guardians/carers consent to chiropractic care of a child. To acknowledge that consent, please would you sign below?

1st Signatory 2nd Signatory.....

Please would you complete as many of the questions below as possible. Details need not be given as most points will be discussed during your appointment.

Maternal history – age at delivery.....

History of stillbirths...Y/N History of miscarriages.....Y/N

Did you suffer with Hypertension...Y/N Heartburn...Y/N Pubic pain....Y/N

Proteinuria...Y/N Pre-eclampsia....Y/N Placenta-Previa....Y/N

During pregnancy did you smoke...Y/N drink alcohol.....Y/N ultrasound.....Y/N

drink tea or coffee....Y/N used prescribed drugs....Y/N Dental work....Y/N

During the delivery did you use any pain relief.....Y/N

Please specify.....

Did your waters break spontaneously.....Y/N

Did you require an epidural.....Y/N Caesarean.....Y/N Forceps....Y/N

Ventouse....Y/N

Any complications....Y/N

If yes please specify.....

Length of labour (contractions)..... Pushing stage.....

Newborn History

Did your baby have any breathing difficulties at birth...Y/N

Apgar score at 1 minute..... At 5 minutes.....

Weight at birth..... first recorded length..... Age.....

First recorded head circumference..... Age.....

Any visible bruising on you baby after delivery.....Y/N

If yes please describe.....

Is your baby breast fed.....Y/N

Have there been any problems establishing feeding.... Y/N

If yes, have you received any help.....Y/N

How often do you feed your baby.....

Is your baby bottle fed.....Y/N

Which formula do you use.....

How many feeds does your baby have in 24 hours.....

How many ounces at each feed.....

Is your baby sleeping well.....Y/N

Please describe your routine at the moment.....

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Does your baby show any signs of colic.....Y/N

Does your baby vomit.....Y/N Do they suffer with trapped wind....Y/N

Has your baby been vaccinated.....Y/N

Did they have any reaction to the vaccination.....Y/N

If yes, please specify.....

Do you have any concerns about your baby's bowel actions.....Y/N

Bladder function.....Y/N

Skin.....Y/N

Eye function.....Y/N

Hearing.....Y/N

Shape of head... ..Y/N

Please bring this form with you to the consultation, as it is a significant part of your baby's case notes. At the consultation all aspects of your baby's health will be discussed and a paediatric examination will be performed. This will consist of assessing growth and development and screening a series of baby reflexes. Your baby's spine will be examined and all findings discussed in detail with you.

Please would you just indicate below the main purpose for your visit?

Check-up only, no known problems.....

Main health concern, please specify.....

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Thank you, for taking the time to complete this form, I look forward to meeting you and your baby.