

Paediatric Case History Form (6mths-5years)

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.....

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.....

At what age did your child crawl..... walk..... talk.....

At what age did you wean your child.....

Did they ever struggle with solid food..... Y/N

Does your child have a balanced diet..... Y/N

Do they eat fruit and vegetables..... Y/N

Do they eat a high proportion of junk food..... Y/N

Do they have any allergies that you know of..... Y/N

Do they suffer with any bowel or bladder disorders..... Y/N

At what age did you achieve daytime dryness..... night-time.....

Is there any history of colic....Y/N	Vomiting....Y/N	Diarrhoea.....Y/N
Feeding problems.....Y/N	Constipation.....Y/ N	Asthma.....Y/N
Skin disorders.....Y/N	Ear Infections... Y/N	Bronciolitis...Y/N
Head Trauma...Y/N	Fractures..... Y/N	Surgery.....Y/N

Do you have any concerns regarding your child's sight....Y/N Hearing.....Y/N

Does your child struggle with balance or co-ordination.....Y/N

Do you ever notice a strange position of the feet or knees when either standing, walking or running.....Y/N

If yes, please specify.....

Does your child exhibit any behavioural disturbances.....Y/N

If yes, please specify.....

Does your child ever get nightmares.....Y/N

Does your child attend a nursery or school..... Y/N

How many hours a week.....

Does your child have any learning problems.....Y/N

If yes, please specify.....

Do you have any concerns regarding your child's social skills, either at home, nursery or school.....Y/N

If yes, please specify.....

Please bring this form with you to the consultation, as it is a significant part of your child's case notes. At the consultation all aspects of your child's health will be discussed and a paediatric examination will be performed. This will consist of assessing growth and neurological development. Your child'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 child.