PAEDIATRIC 0-4 years CONFIDENTIAL PATIENT CASE HISTORY

(PLEASE PRINT)

Child's Name _____Date of Birth_____

Parent Name(s): Mum_____Dad_____ *Please circle who is filling out form*

Names & ages of siblings_____

Address _____Town/City_____Postcode_____

Home Ph_____ Mobile _____ Health Fund_____

Email address of parent or guardian _____

GP/Paediatrician Details _____

Pre-School Teacher_____

How did you hear about our clinic? ☐Friend or Acquaintance (name) _____

☐Family member (name): _____

☐Another Health Professional (please specify) _____

☐Website

☐Other _____

What is the main reason for your child's visit to the practice? _____

_____

During pregnancy, did the child's mother have…

Tabaco/ Alcohol/ Non-prescription drugs Y ☐ N ☐

Prescription medication Y ☐ N ☐

History of high blood pressure or pre-eclampsia Y ☐ N ☐

Labor and Delivery History

How long was the pre- Labor? _____

How long was the pushing (2nd) stage of the labor _____

Please tick ☐any that applies

☐ Hospital Birth ☐ Home Birth ☐ Midwife Assisted

☐ Vaginal Delivery ☐ Planned C-Section ☐ Emergency C-Section ☐ Induced

☐ Forceps delivery ☐ Vacuum Extraction

□ Anesthesia Administered □ Fetal distress

□Head presentation □ Breech presentation □ Transverse presentation

Child's condition after Birth:

Apgar Scores at Min1 _____ Min 5 _____ □ Don't Know

Birth Weight_____ kilos Length_____ cm Head Circumference_____ cm

New Born History

How many hours of sleep does your baby do between feeds? During Day_____ During Night_____

Does your baby have a preferred sleeping position? Y□ N□ If yes explain

_____

Does your child have feeding difficulties? Y□ N□ _____

Is your baby breast fed? Y□ N□ Till what age_____ If not, what age did you start formula _____mths

Does your child have any allergies or food sensitivities? Y□ N□ _____

Does your child spit-up after feeding? Y□ N□

Does your baby cry a lot? Y□ N□

Does your baby cry in the car? Y□ N□

Does your baby have a flat spot on their head? Y□ N□ If Yes which side L□ R□

Has your child had any serious falls? Y□ N□ _____

Has your child had any other injuries? Y□ N□ _____

Has your child been hospitalised? Y□ N□ _____

_____

Does your child take any medication or supplements? Y□ N□ _____

Has your child had antibiotics in the first 2 years of life? Y□ N□

Growth and Development (where relevant please fill in)

Did your child roll to both sides? Y□ N□ If no, they predominantly roll to the… L□ R□

Can your child sit unsupported? Y□ N□ At what age did this begin_____ mths

Is your child crawling yet? Y□ N□ They started crawling at… _____ mths

Is it opposite hand and leg crawling? Y□ N□ If No, how do they crawl? _____

_____

Is your child walking yet? Y□ N□ They started walking at… _____ mths

Do you have any concerns about their walking? Y ☐ N ☐ If yes please explain

_____

_____

Does your child ever complain of back, neck or limb pain? Y ☐ N ☐

Does your child ever complain of pins and needles or numbness in the legs or arms? Y ☐ N ☐

Does your child ever complain of headaches? Y ☐ N ☐

How would you rate your child's vocabulary? ☐ Poor ☐ Average ☐ Above Average ☐ Don't know

How would you rate your child's social development? ☐ Poor ☐ Average ☐ Above Average ☐ Don't know

Describe your child's temperament from 2-4 years old (*if applicable*) _____

_____

Systems History

Has your child had any ear infections? Y ☐ N ☐ If yes how many and which ear? L ☐ _____ R ☐ _____

Does your child get cold easily? Y ☐ N ☐

Does your child have asthma, bronchiolitis or any other respiratory conditions? Y ☐ N ☐ (please circle)

Does your child suffer from constipation or diarrhea? Y ☐ N ☐

Does your child wear glasses? Y ☐ N ☐

Has Your Child Ever Been Evaluated By or is Currently Seeing: (please provide name and clinic)

☐ Neurologist _____

☐ Paediatrician _____

☐ Psychiatrist/Psychologist _____

☐ Occupational Therapist _____

☐ Speech or language Therapist _____

☐ Other, Please specify: _____

Please Tick ☐ any of the following that apply to your child

☐ Finds it hard to form friendships

☐ Problems paying attention

☐ Is hyperactive and/ or impulsive

☐ Argues all the time and is generally very uncooperative

☐ Repetitive motor mannerisms

☐ Fidgets excessively

☐ Extremely shy around strangers

☐ Difficulty with fine motor skills

□ Toe walker

□ Failure to reach any milestone

□ Poor coordination or clumsiness

□ Has difficulty in pronouncing words

□ Gets motion sickness

□ Poor eye contact

Do you have any other concerns you wish to discuss?

Policies on Fees, Guarantees, Disclosed Information & Research:

1) I understand that appointments not attended or cancelled with less than 24 hours notice may incur a charge and that payment is required at the time of consultation.

2) I appreciate that **positive results of any treatment** that I receive at NeuroBalance Chiropractic **is no guaranteed**. I understand that the team at NeuroBalance does not aim to treat my symptoms, but addres any dysfunction identified.

3) I have disclosed any past or current illness, surgery, previous trauma, medications, drug use and any known health risks in the forms and questionnaires provided, and **agree to provide any related new information** during the period of care at this clinic or by practitioners who have assessed or treated me a this clinic.

4) Information gained from the initial assessment and follow up sessions **may be used for interna research purposes** or **publishable research** to help establish improved assessment and treatmen protocols and promote a greater understanding of this field of healthcare in the scientific community. No personal details (name, contact details etc.) will be disclosed in any published material.

Consent to Examination and Treatment of a Minor

I hereby authorise the doctors at NeuroBalance Chiropractic and whomever they may designate as thei assistants to administer care as deemed necessary to my child. I hereby also consent to the performance o an assessment by the chiropractor including physical, neurological and orthopaedic tests.

I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment to NeuroBalance Chiropractic at the time of service.

_____

Name of Child

_____

Signature of Parent (or Guardian) **Date**

Our aim is to provide your child with the highest possible care. To enable us to best manage any treatment for your child, do you give consent for us to liaise with their other health care professionals and pre-school?

□ **YES** □ **NO**