221 Longueville Road, Lane Cove NSW 2066. Tel: 9418 3930

***Parents**, please complete this form as accurately as possible as this information will help us determine how Chiropractic may help your child.*

Catherine von Thomann & Shannon Egan

PAEDIATRIC HISTORY

CHILD'S FULL NAME: _____
ADDRESS:_____

_____

_____

TELEPHONE: HOME_____
MOTHERS NAME: _____
MOBILE:_____
FATHERS NAME: _____
MOBILE:_____
EMAIL ADDRESS: _____

CHILDS DATE OF BIRTH:_____**AGE:**_____

NAMES OF SIBLINGS	M/F	DOB	AGE

WHAT CONCERNS DO YOU HAVE REGARDING THE HEALTH OF YOUR CHILD?_____

_____

IS THERE A FAMILY HISTORY OF <u>ANY</u> HEALTH CONDITIONS?
(eg asthma, cancer, high blood pressure, migraine, diabetes)

NAME	RELATION	PAST & PRESENT HEALTH PROBS

HAS YOUR CHILD EVER HAD PREVIOUS CHIROPRACTIC CARE?
YES☐ NO☐ LOCATION OF CLINIC_____
FOR WHAT REASON?_____
LAST VISIT_____**NAME OF CHIRO**_____
X-RAYS TAKEN? YES☐ NO☐
HOW WOULD YOU DESCRIBE THE CARE RECEIVED

POOR	FAIR	GOOD	EXCELLENT

BIRTH/DELIVERY INFORMATION

	YES	NO		YES	NO
VAGINAL	☐	☐	BREECH	☐	☐
TO TERM	☐	☐	(TYPE_____)		
PREMATURE	☐	☐	OVERDUE	☐	☐
CAESARIAN	☐	☐	FORCEPS	☐	☐
CHEM. INDUCED	☐	☐	SUCTION/VACUUM	☐	☐

OTHER_____
_____
BIRTH WEIGHT: _____
APGAR SCORES:_____ _____ _____

DURATION OF FULL LABOUR: _____ **hours**
DURATION OF 2ND STAGE (PUSHING): _____ **hours/mins**

DO YOU BELIEVE THE BIRTH WAS TRAUMATIC FOR YOUR CHILD? YES☐ NO☐

WAS YOUR CHILDS HEAD MIS-SHAPEN AT BIRTH? YES☐ NO☐

ANY DELIVERY COMPLICATIONS? YES☐ NO☐
_____
_____

WAS YOUR CHILD-	YES	NO	
• BREASTFED	☐	☐	HOW LONG_____
• FORMULA FED	☐	☐	HOW LONG_____TYPE____

DID/DOES YOUR CHILD SUFFER-
- **REFLUX? YES☐ NO☐ MILD MODERATE SEVERE**
- **COLIC? YES☐ NO☐ MILD MODERATE SEVERE**

SLEEP HABITS

V.GOOD	GOOD	AVERAGE	POOR	V.POOR

PLEASE TICK ANY OF THE FOLLOWING RELEVANT TO YOUR CHILD

GROWING PAINS	☐	**NECKPAIN**	☐
BACKPAIN	☐	**ARM/LEG PAIN**	☐
JOINT PAIN	☐	**HEADACHE**	☐
ALLERGIES	☐	**SINUS**	☐
RECURRENT TONSILLITIS	☐	**RECURRENT CHEST INFECTIONS**	☐
RECURRENT EAR INFECTION	☐	**EARACHE**	☐
DIGESTIVE PROBS	☐	**DIARRHOEA**	☐
LOSS OF APPETITE	☐	**CONSTIPATION**	☐
FEVER	☐	**RECURRENT STOMACH ACHES**	☐
HYPERACTIVITY	☐	**POOR CO-ORDINATION**	☐
POOR SLEEP HABITS	☐	**CONSTANT FATIGUE**	☐
LEARNING DIFFICULTY	☐		
EXCESSIVE THIRST	☐	**TRAVEL SICKNESS**	☐
SEIZURES	☐	**VISION PROBS**	☐
DIZZINESS	☐	**POOR CONCENTRATION**	☐
TEETHING DIFFICULTY	☐	**GRINDING TEETH**	☐
SCOLIOSIS	☐		

HAS YOUR CHILD SUFFERED ANY OF THE FOLLOWING DISEASES OR ILLNESS

☐APPENDICITS	☐PNEUMONIA	☐WHOOPING COUGH	☐ANEMIA
☐MEASLES	☐MUMPS		☐CHICKEN POX
☐DIABETES	☐ASTHMA	☐ECZEMA	

OTHER ILLNESS-_____

_____

_____

MEDICAL HISTORY

HOW LONG DID YOUR CHILD CRAWL FOR?_____

IS YOUR CHILD ACCIDENT PRONE? YES☐ NO☐
PLEASE COMMENT ON SIGNIFICANT FALLS._____
_____
_____

HAS YOUR CHILD EVER BEEN INVOLVED IN A MOTOR VEHICLE ACCIDENT? YES☐ NO☐_____
_____

DOES YOUR CHILD HAVE A LEARNING DISORDER?YES☐ NO☐
_____

DOES YOUR CHILD TAKE REGULAR MEDICATION?
YES ☐ NO ☐
TYPE, DOSAGE ETC._____
_____

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? YES☐ NO☐
IF YES, HOW OFTEN WITHIN THE LAST SIX MONTHS_____
_____
_____

HOW OFTEN HAS YOUR CHILD TAKEN ANTIBIOTICS DURING LIFETIME?_____

HAS YOUR CHILD RECEIVED THE RECOMMENDED SCHEDULE OF CHILDHOOD VACCINATIONS? YES ☐ NO ☐
OTHER VACCINATIONS-_____
_____

HAS YOUR CHILD EVER BEEN HOSPITALISED OR HAD SURGERY? YES☐ NO☐
_____
_____

HAS YOUR CHILD BEEN DIAGNOSED WITH SCOLIOSIS?
YES☐ NO☐
WHO MADE THE DIAGNOSIS?_____