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(0-5)

Child's Name: _____ Date: _____ Referred By:_____

Address:_____City:_____ Post Code:_____

Date of Birth:_____ Age:_____ Gender: M / F

Mother's Name: _____Mobile No:_____ Home Phone:_____

Father's Name: _____Mobile No:_____ Home Phone:_____

Primary Contact Email Address: _____

Names and ages of siblings: _____

Paediatrician's Name: _____ Clinic Name: _____

When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your child's care here, if relevant? Y / N

Labour & Delivery

Third Trimester Presentation: Vertex_____ Breech _____ Transverse _____ Face/Brow_____

Type of Birth: Normal Vaginal_____ Forceps _____ Caesarean _____ Suction Cap/Vacuum _____

Location: Home_____ Birthing Centre _____ Hospital _____ No. hours in labour_____ Pushed for: ____mins

Problems during pregnancy: _____

Problems during labour/delivery: _____

Any medications administered at birth: _____

Apgar Scores: _____ _____ At the time of birth, was the child: Jaundice (yellow) Y/N Cyanosis (blue) Y/N

Birth weight: _____ Birth Height: _____ Current Weight: _____

Did the mother use any cigarettes, alcohol or medications during pregnancy? Y/N

Did the mother use any supplements, vitamins or homeopathies during pregnancy? Y/N

Was the mother involved in any accidents during pregnancy? Y/N

Number of ultrasounds during pregnancy _____

Any other tests carried out during pregnancy? _____

At how many weeks did you deliver? _____

Were you: Chemically induced? Y/N Administered an epidural? Y/N

Congenital Anomalies / Defects? Y/N If yes, please explain: _____

Past & Current Health History

Please check each of the following your child has currently, or has had in the past:

___ Measles/Mumps
___ Chicken Pox
___ Eczema/Skin Problems
___ Pneumonia
___ Asthma/Wheezing
___ Cancer
___ Hepatitis
___ Allergies
___ Frequent colds/sore throat
___ Diarrhoea
___ Constipation
___ Colic
___ Ear infection
___ Tonsilitis
___ Back pain
___ Headaches
___ Dizziness
___ Fainting
___ Seizures/Convulsions
___ Anaemia
___ Bed Wetting
___ Behavioural problems
___ ADD/ADHD
___ Ruptures/hernia
___ Growing pains
___ Sleep problems
___ Speech problems
___ Emotional problems
___ Nightmares
___ Co-ordination problems
___ Stomach Aches
___ Reflux
___ Diabetes
___ Heart Trouble
___ Orthopaedic problems
___ Neck Pain
___ Joint problems/pain
___ Scoliosis
___ Walking trouble
___ Broken bones
___ Digestive disorder
___ Poor appetite
___ Fever
___ Hip/leg pain
___ Concentration problems

Please list any allergies: _____

What concerns do you have regarding the health of your child (if any)?_____
_____

Please list any medications your child is currently taking: _____

Please list any supplements/vitamins your child is currently taking: _____

Number of doses of antibiotics your child has taken in his/her life: _____

Has your child ever suffered from the following spinal traumas?

___ Fall in baby walker
___ Fall from crib
___ Fall from highchair
___ Fall from changing table
___ Fall from bed or couch
___ Fall off swing
___ Fall off slide
___ Fall off monkey bars
___ Fall off skateboard or skates
___ Fall off bicycle
___ Fall down stairs
___ Other: _____

Date of last visit to paediatrician: _____ Purpose of visit: _____

Has your child ever been treated on an emergency basis? Y/N Details:_____
_____

Did you choose to vaccinate your child? Y/N
If Yes, which vaccines? All/None If a few, please list: _____

At what age did your child:

Sit _____ Crawl _____ Walk _____ Talk _____
Respond to sound _____ Hold head up _____ Follow an object with his/her eyes _____

The following questions are designed to allow the doctor to provide a detailed evaluation of your child. If a question is not relevant to your child's age, please put N/A.

How many hours does your baby sleep between feeds? During Day ____ At Night ____

Does your child go to sleep easily? Y/N

Does your child have a preferred sleeping position? Y/N

Does your child cry if you change this sleeping position? Y/N

Does your child have any difficulties feeding? Y/N

Is your baby being breast fed? Y/N If No, for how long was baby breast fed? _____weeks/months

Does your baby have a one sided breast feeding preference? Y/N Preferred breast Left/Right

Is your child formula fed? Y/N Which formula or other milk source? _____

Does your baby frequently spit up after feeding? Y/N

Is your child eating solid food? Y/N What foods does his/her diet contain? _____
_____What is your child's favourite food? _____

Does your child have any food allergies? Y/N If Yes, please list: _____

Does your child cry a lot? Y/N For how many hours a day? _____

Does your baby pass a lot of intestinal gas? Y/N

Does your baby have a preferred head position? Y/N _____

Does your baby frequently arch his/her head and neck backwards? Y/N

Does your baby cry or become irritable during a nappy change? Y/N

Does your child refuse to make eye contact? Y/N

Does your child ever bang his/her head against a wall repeatedly? Y/N

Does your child watch TV/play computer games? Y/N If yes, how many minutes/hours per day? _____

Does your child have any hobbies/favourite sports? _____

Do you have any other concerns you want to discuss? Y/N _____

Has your child ever received chiropractic care? Y/N If Yes, who? _____
What were the results? _____

Is your child under the care of a specialist? Y/N Is this for the same concern? Y/N

Print Name:

_____

I can confirm that the above is a full and accurate disclosure of my child's health and medical status.

Signature_____ Date_____

I authorise Dr Arleen Scholten DC to examine and adjust my child's spine/extremities/cranium as she deems appropriate, (or a locum doctor authorised by Dr Arleen Scholten, in her absence) through the use of Chiropractic methods.

Signature: _____Date: _____