Peadiatric : 1-5 YEARS OLD

THANK YOU FOR TAKING THE TIME TO FILL IN THIS FORM:

CHILD'S NAME M / F DOB:

ADDRESS

PARENT/GUARDIANS NAME: RELATIONSHIP:

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PARENT PHONE: HOME: MOBILE:

PARENT EMAIL:

NAME OF PEDIATRICIAN/DOCTOR:

CURRENT CONCERN WITH YOUR CHILD

WHO CAN WE THANK FOR REFERRING YOU?

GENERAL HEATH HISTORY: PLEASE CHECK YES OR NO FOR THE FOLLOWING:

PRENATAL (CONCEPTION TO BIRTH)
WHILE PREGNANT WITH THIS CHILD DID THE MOTHER:

Smoke ☐ YES ☐ NO

Drink Alcohol ☐ YES ☐ NO

Have any falls or injuries ☐ YES ☐ NO

Any prescribed medication ☐ YES ☐ NO

Have x-rays or Ultrasounds ☐ YES ☐ NO

Duration of the pregnancy in weeks

Age of mother at time of birth

Perinatal (Birth)

Place of Birth ☐ Home ☐ Hospital ☐ Birthing Centre Childs Weight__________________

Provider ☐ Midwife ☐ Medical doctor ☐ Other APGAR Score 1 min____ 5min____

Type of Birth ☐ Vaginal ☐ Caesarean Section

Use of Drugs During Birth ☐ YES ☐ NO

Forceps or Vacuum Extraction ☐ YES ☐ NO Was Labour Induced ☐ YES ☐ NO

NEW ENGLAND CHIROPRACTIC

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NEONATAL

IMMEDIATELY AFTER BIRTH/DURING INFANCY DID ANY OF THE FOLLOWING OCCUR?

NEED FOR CHILD TO BE RESPIRATED ☐ YES ☐ NO

NEED FOR CHILD TO BE IN A HUMIDICRIB ☐ YES ☐ NO

ADMINISTERED MEDICATIONS ☐ YES ☐ NO TYPE ______________________________

DIFFICULTY FEEDING/LATCHING/SUCKING ☐ YES ☐ NO

FALLS ONTO HEAD ☐ YES ☐ NO HEAD BANGING ☐ YES ☐ NO

RECENT ILLNESS ☐ YES ☐ NO SURGERY ☐ YES ☐ NO

FAILURE TO GROW/GAIN WEIGHT ☐ YES ☐ NO

DISRUPTED SLEEP PATTERNS ☐ YES ☐ NO

HOURS OF SLEEP PER NIGHT____________ LENGTH OF NAPS IN DAY _____________

SPEECH OR LANGUAGE DIFFICULTIES ☐ YES ☐ NO

FOOD ALLERGIES ☐ YES ☐ NO IF YES, LIST____________________________________

☐ BREAST FED UNTIL WHAT AGE______________________________

☐ FORMULA FED TYPE OF FORMULA___________________________

PLEASE CIRCLE ANY RELEVANT CONDITIONS BELOW

TEETH	EYES	HEARING	COUGHS/COLDS	HEADACHE
BACKACHE	GAS	COLIC	CONSTIPATION	DIARRHOEA
REFLUX	EAR ACHE/ Infections	SKIN RASHES	FREQUENT URINATION	DIFFICULT URINATION
SLEEP ISSUES	FLAKING SCALP	HYPERACTIVE	UNDER ACTIVE	MUSCLE TONE
DEVELOPMENT DELAY	ANXIETY/ DEPRESSION	ASTHMA/ CHRONIC BRONCHITIS	SINUS/ ALLERGIES	ADHD/ ADD

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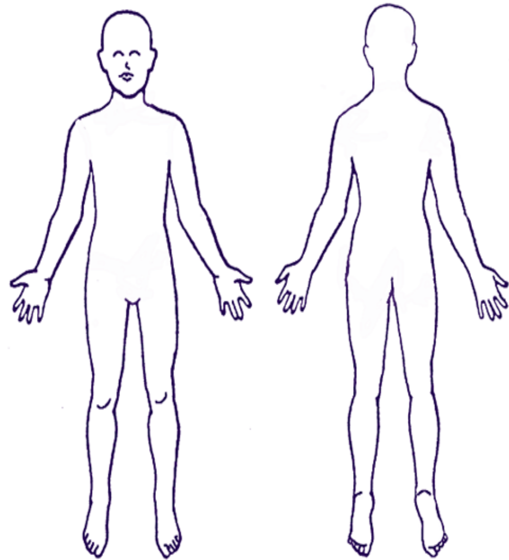
MEDICAL HISTORY:

Has your child experienced any of the following:

Fall from crib/ change table	YES	NO
Failure to Thrive	YES	NO
Fall from playground equipment/bike/tree/etc	YES	NO
More than 2 ear infections	YES	NO
Repeated Infections or colds	YES	NO
Night pain	YES	NO
Convulsions/seizures/epilepsy	YES	NO
Sleeping Difficulties	YES	NO
Headaches	YES	NO
Stomach Pains	YES	NO
Toe Walking	YES	NO
Frequent Diarrhoea/constipation	YES	NO
Difficulty swallowing	YES	NO
Unusual movements/Tics	YES	NO
Involved in MVA (car accident)	YES	NO
Poor or excessive weight gain	YES	NO

Please Mark on the diagram below where your child is experiencing or showing signs of discomfort:



Has your child been diagnosed with a developmental disorder
☐ YES ☐ NO, if yes, please describe

____

Is your child currently on any medications, or taken any In the past ☐ YES ☐ NO
If yes, please list what and why?

____

____

____

Is there anything else you would like the Chiropractor to know?

____

____

DEVELOPMENT

Please Answer the following with one of:
>6mths/6-12mths/12-18mths/18-24 mths/24-36mths/36-48mths/<48mths

Approximately how old was your child when they first:

Crawled_________________________

Sat unsupported _________________________

Stood unsupported _________________________

Walked unsupported _________________________

Toilet Trained (bladder)____________ (Bowel) ____________

Began to Vocalize (babble) _________________________

Began to use words _________________________

Began to use sentences _________________________

Which hand does your child prefer _________________________

SOCIAL SKILLS

Does your child?

Avoid Affection ☐ YES ☐ NO
Have Temper Tantrums/ Lose temper easily ☐ YES ☐ NO

Mood change easily ☐ YES ☐ NO
Use Repetitive movements when stressed or excited ☐ YES ☐ NO

Anxious in new situations ☐ YES ☐ NO
Avoid eye contact with people ☐ YES ☐ NO

Get distracted easily ☐ YES ☐ NO
Gets frustrated easily ☐ YES ☐ NO

How long can your child sit while watching a fascinating activity or being read to? _________________________