NEW ENGLAND CHIROPRACTIC

Peadiatric : 6-12 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

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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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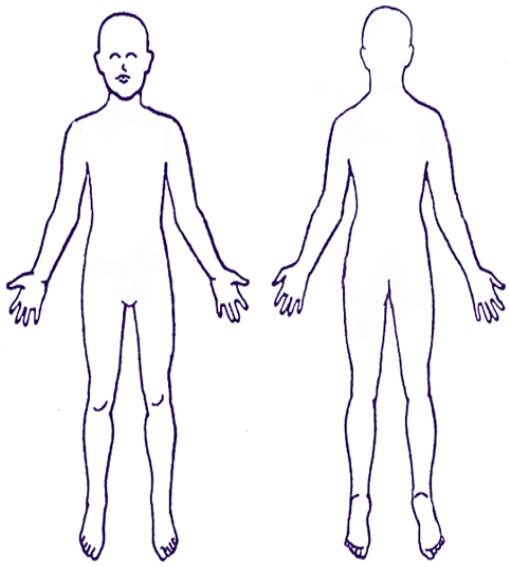
MEDICAL HISTORY:

Has your child experienced any of the following:

Sports Accidents	YES	NO
Leg/knee pains	YES	NO
Fall from playground equipment/bike/tree/etc	YES	NO
Tumble down stairs	YES	NO
Repeated Infections or colds	YES	NO
Night pain	YES	NO
Convulsions/seizures/epilepsy	YES	NO
Bed wetting beyond age 5	YES	NO
Headaches	YES	NO
Stomach Pains	YES	NO
Scoliosis	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?

_____

_____

_____

Does your child participate in any of the following?

☐ Soccer ☐ Rugby ☐ Tennis
☐ Hockey ☐ Gymnastics ☐ Cycling
☐ Swimming ☐ Dance ☐ League/AFL
☐ Martial Arts

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

_____

_____

How would you rate your childs diet?

☐ Well-Balanced ☐ Average ☐ Poor

_____

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? _____