Naturally Chiropractic

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Child new patient medical history

Childs name ..... Parents names .....

Date of birth ..... How did you hear about us? .....

Address .....

.....

Telephone number ..... Email .....

Pregnancy

Did your pregnancy go to term? ☐ yes ☐ no How many weeks? .....

Please describe any problems you had during your pregnancy, however minor .....

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Did you have any ultrasound scans? ☐ yes ☐ no How many? .....How long did they last? .....

Did you have any other tests (e.g. amniocentesis?) ☐ yes ☐ no

If yes, please describe .....

Did you take any medication during your pregnancy? (include homeopathic remedies, supplements also) .....

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Did your labour start naturally or through induction? ..... How long did labour last once established? .....

Did you have any intervention? (e.g. forceps, ventouse) ..... Did you have any pain relief? .....

Was mum involved in any accidents prior to conceiving or during pregnancy? If yes, please describe .....

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Baby and childhood

Please list any vaccinations .....

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Did they suffer any reaction to any of the vaccinations given? If yes, please tick any of the relevant reactions below:

☐ fever ☐ convulsions ☐ irritability ☐ asthma/allergies ☐ ear infections

☐ sleeping difficulties ☐ eating difficulties ☐ Autism/learning difficulties ☐ Local swelling at injection site

☐ other? If yes, please describe.....

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Sleep

Do they sleep well? ☐ yes ☐ no Are they swaddled when they sleep? ☐ yes ☐ no

Do they sleep on their ☐ front ☐ back ☐ side

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Feeding Are/were they breast fed? ☐ yes ☐ no If yes, for how long? .....

Does/did mum suffer from any discomfort, breast or nipple problems .....

Do/did they feed better to one side? ☐ yes ☐ no If yes, which side? .....

Do they feed efficiently and well? ☐ yes ☐ no Do they suffer any food allergies or intolerances? ☐ yes ☐ no

If yes, please describe .....

Nappies How often do they fill their nappies? .....What colour is it? .....

Do they struggle to poo or pass wind? .....

General health Have they had any hospitalisations? ☐ yes ☐ no If yes, please describe .....

.....

Please list any childhood illnesses .....

.....

Do they suffer from any of the following? If yes, please tick boxes:

☐ headaches	☐ ear infections	☐ concentration issues	☐ sore throat	☐ tonsillitis
☐ hoarse voice	☐ swallowing problems	☐ jaw pain/clicking	☐ neck pain	☐ asthma
☐ conjunctivitis	☐ epilepsy	☐ sight problems	☐ hearing problems	☐ sinus problems
☐ wind	☐ growing pains	☐ stomach aches	☐ constipation	☐ diarrhoea
☐ fatigue	☐ rashes	☐ fainting	☐ loss of consciousness	

Activities Are they clumsy or co-ordinated? .....

Have they been involved in any accidents? If yes, please describe. .....

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Please describe any learning difficulties .....

.....

Do they play sports? yes ☐ no ☐ If yes, what? .....

Have they suffered any sporting injuries? yes ☐ no ☐ If yes, please describe .....

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Please describe any current health issues or concerns .....

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Parental consent

Declarations:

The above information is to the best of my knowledge true and correct ☐

I have read and understood the 'Informed Consent' information given to me ☐

I give consent for my child to undergo a chiropractic examination at Naturally Chiropractic ☐

I give consent for my child to undergo chiropractic treatment at Naturally Chiropractic ☐

Parent/guardians full name .....Relationship to the child .....

Signature. .....Date .....