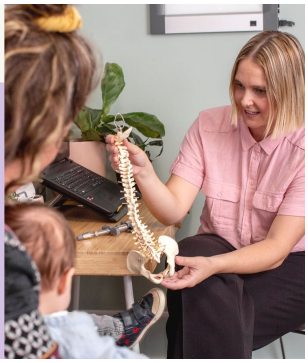
ELEVATE PAEDIATRICS
CHIROPRACTIC 4 KIDS

The Paediatric Initial Consultation



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Gain the confidence of the parents

Educate and inform the parents

Examination of the Child

Commitment to a healthcare class/talk/workshop

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The Paediatric Case History Form

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CHILD SPINAL AND POSTURAL EXAMINATION

Dear Parent,
It is our pleasure to welcome you to our clinic. Please carefully complete the following questionnaire. Your answers will help us to determine how chiropractic may benefit your child. Please note this is a postural and spinal examination *only*. No chiropractic treatment will be provided today. If treatment is required you will be advised of this and an appointment can be made for a later date.
Thank You.

Name of Child:_____ D.O.B.: ___/___/____ Age: ____

Parents Names: Father_____

Mother_____

Address: _____

_____

Contact Phone Numbers:

Home_____Mobile_____Work_____

Email _____

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Other Children's Names: Have they had a previous chiropractic examination?

_____D.O.B.___/___/____ Age_____ Yes / No

_____D.O.B.___/___/____ Age_____ Yes / No

_____D.O.B.___/___/____ Age_____ Yes / No

_____D.O.B.___/___/____ Age_____ Yes / No

_____D.O.B.___/___/____ Age_____ Yes / No

How did you hear about our practice? (please circle)

Staff Member ..... Friend ..... Family ..... Internet .....

Doctor ..... Maternal Health Nurse ..... Other health practitioner .....

Information in reception Y.P.'s Healthcare Class Other: .....

Do you have private health insurance for chiropractic? Yes/ No / Unsure

Name of company_____

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What concerns do you have regarding the health of your child?

_____

_____

_____

_____

_____

PREGNANCY

Did you require any medication through your pregnancy? Yes / No .....

Were there any complications through your pregnancy? Yes / No

_____

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BIRTH

The birth of your child can give vital clues as to potential spinal problems. Please answer the following questions about the delivery and birth of your child.

Home / Hospital Delivery ..... Drugs during delivery Yes / No

Delivered Normally	Yes / No	Breech	Yes / No
Posterior	Yes / No	Premature	Yes / No
At Term	Yes / No	Caesarian	Yes / No
Late	Yes / No	Forceps	Yes / No
Chemically Induced	Yes / No	Suction	Yes / No

Other _____

Birth weight: _____ Apgar Scores _____ _____

How long were you in labour ? _____Hours How long did you "push" for?___ Mins / Hrs

Do you believe the birth was traumatic for your child? Yes / No

Was your child's head mis-shapen at birth? Yes / No

Were there any delivery complications? Yes / No

Details _____

_____

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BIRTH TO SIX MONTHS

Was your child breast fed? Yes / No For how long? _____

Were there attachment issues? Yes / No Details: _____

Was your child formula fed? Yes / No For how long? _____ Type _____

Did your child suffer with colic? Yes / No If yes, how bad was it? Mild Moderate Severe

Did your child suffer with reflux? Yes / No If yes, how bad was it? Mild Moderate Severe

Would you say your child was a:

Very poor sleeper Poor sleeper Average sleeper Good sleeper Very good sleeper

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OTHER PROBLEMS

Please indicate by circling any of the following conditions which your child has experienced in the past:

Headache	Allergies	Neck pain
Back pain	Constipation/Diarrhoea	Earaches/Infections
Sinus pain	Recurrent tonsillitis	Bedwetting
Recurrent chest infections	Growing pains	Hyperactivity
Loss of appetite	Poor sleeping habits	Visual disorders
Constant fatigue	Arm/ Leg pain	Recurrent stomach aches
Scoliosis	Fever	Convulsions
Joint pains	Asthma	Travel sickness
Night terrors	Seizures	Chronic colds
Recurring fevers	Hip problems	Digestive disorders
Developmental Delay	Poor social skills	Extremely messy eater

Other _____

School Age Child:

Poor co-ordination	Learning difficulties	Poor hand writing
Behavioural Issues	Diagnosed as ADD/ADHD	Delayed verbal communication
Diagnosis of Autism	Difficulty with reading / writing / spelling	Extreme clumsiness

Other _____

MEDICAL HISTORY

What age did your child begin crawling? ..... How long did your child crawl for? .....

Is your child accident prone? Yes / No Has your child has any significant falls? Yes / No

Please describe any falls or accidents your child has had.

_____

_____

Has your child ever been involved in a motor vehicle accident? Yes / No

Is your child on medication? Yes / No Details: _____

Is your child vaccinated? Yes / No

Has your child had any diseases/ illnesses? Yes / No Details: _____

Has your child ever been hospitalised or had surgery? Yes / No Details:

_____

Has your child ever had any broken bones or sprain injuries? Yes / No Details:

_____

Has your child ever been assessed for the presence of scoliosis? Yes / No

How many times has your child taken antibiotics? In last six months ____ During lifetime ____

How many doses of other Prescription Medication has your child taken?

In last six months _____ During lifetime _____

What was the medication for? _____

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PREVIOUS CHIROPRACTIC CARE

Has your child had previous chiropractic care? Yes / No

Reason for care _____

Date of last care ____/____/_____ Name of Chiropractor_____

Location of Clinic _____ Were x-rays taken? Yes / No

How would you describe the care received? Excellent Good Fair Poor

Further Comments _____

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Reviewing the Paediatric Case History Form

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Greeting the parents

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"Now, you may have heard that as chiropractors we work with the spine. While this is true, what we really work with is the nervous system"

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Taking the History

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- Was your child's head misshapen at birth?
- Did your child breastfeed symmetrically?
- How long as your child walked with a turned in foot?
- Does your baby favour turning their head to one side?
- Is your child excessively clumsy?

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Questions on the pregnancy and birth

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- How many previous pregnancies have you had?
- Have you had any miscarriages, stillbirths or neonatal deaths?
- Have you had any complications in any of your previous pregnancies?
- Did you smoke at all during pregnancy? If so, how much?
- Did you drink alcohol during pregnancy? If so, how much?

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- Did you use any recreational or non-prescribed drugs during pregnancy?
- Did you use any over-the-counter or prescription medicine?
- Were any X-rays or ultrasound investigations performed during your pregnancy?
- Did your waters break naturally or were they manually ruptured?

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- Was your baby able to swallow and suck, urinate and pass meconium in the first 24 hours of life?
- Were there any concerns at birth about your baby's weight, length, head circumference, hip joints, heart rate or breathing sounds?
- How did your baby feed in the first few weeks?
- What were your baby's sleeping patterns and crying patterns?
- How would you describe your baby's health generally in the first six weeks?

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Putting their mind at ease

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EXAM ONLY
SAFETY OF CHIRO
ANALOGY OF PRESSURE
VERBAL CONSENT
OBTAINED
ELEVATE
PAEDIATRICS

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EXAMINE WITH CONFIDENCE
ELEVATE
PAEDIATRICS

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