Vaccinations? Y/N
Full vaccine schedule?
Selective schedule?

Major accidents / fractures / operations?
_____

Any other information regarding your child that you feel is relevant?_____
_____

MATERNAL HEALTH

Pregnancy – 1st / 2nd / 3rd etc?

Did you suffer any difficulties conceiving? Y/N
If yes, did you undergo any treatment? (eg fertility treatment, IVF etc)
_____
Any history of miscarriage? Y/N

How would you rate your health prior to conceiving? /10
How would you rate your health prior to pregnancy? /10
How would you rate your health during your pregnancy? /10

Did you suffer any health complications during your pregnancy? Y/N
If yes, please explain _____
Were you hospitalised at any time during your pregnancy? Y/N
If yes, please explain _____
How many ultrasounds did you have during your pregnancy? _____
Were you taking any medications/supplements during your pregnancy? Y/N
If yes, please explain _____
How would you rate your stress levels during your pregnancy? /10

Previous pregnancy (if applicable)

How would you rate your health prior & during your pregnancy? /10
Ultrasounds (number)? _____
Medications? _____
Complications? _____
Hospitalisations? _____

Previous child birth (if applicable)

Vaginal/ caesarean? Please circle
If caesarean, elective or emergency? Please circle

If emergency caesarean, did you labor beforehand? Y/N
If yes, how long?_____

If vaginal, how long was your labor? _____
Interventions
Induction? Y/N Epidural? Y/N Gas? Y/N

MT HAWTHORN CHIROPRACTIC CLINIC

CHILDREN'S CHIROPRACTIC HEALTH QUESTIONNAIRE

Child's name:_____
DOB: _____ **Parent's name (s)**:_____
Address:_____
Contact number: (H) _____ (M) _____

Who may we thank for referring you to this clinic?: (How did you hear about MHCC?)
_____

Major reason for visiting MHCC?: _____

When did this start?: _____

Any previous treatment(s)?: _____

Success of that treatment(s)?: _____

CHILD'S HEALTH

Birth Process
APGAR score (at 5 mins): /10 Birth weight: _____ kgs

Vaginal or caesarean birth? Please circle

Vaginal Birth

Full term (ie 40 weeks)? _____weeks
Labour time? _____hrs
Time from waters breaking to birth? _____mins/hrs
Presentation? (ie occiput anterior, posterior, transverse, breech) Please circle

Interventions
Induction? Y/N
If induced, at what stage? (ie at what week of pregnancy) _____ week
Epidural? Y/N Gas? Y/N
Forceps or vacuum / von teus? Please circle

Caesarean Birth

Elective at what stage? (ie what week of pregnancy) _____week
Reason for elective caesarean?
_____

Emergency at what stage? (ie what week of pregnancy) _____week
Reason for emergency caesarean?
_____

Did you labor before the emergency caesarean? Y/N
If yes, how long? _____hrs

During your labor prior to the emergency caesarean, were any interventions required? Y/N

Interventions
Induction? Y/N
Epidural? Y/N Gas? Y/N

In either a vaginal or caesarean birth, were maternal or infant antibiotics administered? Y/N
Was any intensive care required for either mother or infant? Y/N
(eg blood transfusions, humidicrib etc)

Feeding

Breast or Bottle? Please circle

Breast

Side preference for mother? Y/N if yes L/R
Side preference for child? Y/N if yes L/R

Difficulty with attachment for mother? Y/N
Difficulty with attachment for child? Y/N

Preferred feeding position for mother?
Preferred feeding position for child?

Does the child display any of the following behaviours during breast feeding?
Please circle

Arching back	Shaking head	Vomiting
Gagging	Coughing	Difficulty swallowing
Choking	Dribbling	

Vomiting
Especially with regards to vomiting –
How often? _____
Projectile? Y/N
When? (with regards to feeding ie during, after, between feeds)
_____

Frequency of feeding (hrs)? _____

Duration of feed? _____
Is a feed one breast or both? Please circle

Bottle

Reason for bottle feeding? _____

Expressed? Y/N
Formula? Y/N Which formula? _____

Frequency of feeding (hrs)? _____

Duration of feed? _____

Are there any behavioural changes evident with your child pre or post feed?
(ie irritability, pain, drowsiness etc) _____

Solids? (if applicable) Y/N At what age? _____

Bowel/Bladder

Bowels
Frequency? _____Colour? _____Straining? _____

Bladder
Frequency? _____Smells? _____Pain? _____
Are there any behavioural changes evident with your child pre or post bowel or bladder movement?
_____

Sleeping

Day time sleeps
Number? Duration? Re-settling time?

Night time sleeps
Number? Duration? Re-settling time?

Total number of hours sleep per 24hrs? _____

Preferred sleeping position? _____

Has your child ever suffered or been diagnosed with any of the following? Y/N
Have any of these ever been suffered on a recurrent basis? Y/N
Please circle

Reflux or “silent reflux?
Eczema or skin rashes?
Colic or “uncontrollable irritability?
Ear infections?
Constipation or diarrhoea?
Breathing difficulties (including asthma)?
Urinary tract or bladder infections?
Tonsillitis or adenoids?

Have your child’s developmental milestones been assessed and tracked by a health care professional?
At what age did your child achieve the following milestones – (if known)
Head control?
Sitting?
Rolling?
Hand preference?
Commando crawling?
Crawling?
Walking?

Do you have any concerns regarding your child’s health and/or development?
_____
_____