Dr Heidi Upneck – Nel
M.Tech Chiro

PAEDIATRIC CASE HISTORY

WELCOME TO THORNTON CHIROPRACTIC

Research shows that poorly moving spinal joints can affect how the brain controls and co-ordinates the body's ability to respond to its environment.

Your chiropractor will assess your child's spine and nervous system function and after a careful case history and examination explain if your child has a chiropractic problem.

Please answer these questions thoroughly and to the best of your knowledge.

To enable us to assist you in your health goals please complete the following:

Patient details:

Surname: _____ First Name: _____

Middle initial_____

Address: _____

City:_____ post code: _____

Date of birth: ___/____/_____ Year/Grade at school: _____

Parent/Guardian Details:

Surname: _____First Name:_____ Middle initial:____

Best contact number: H W M : _____

Email: _____

Employer Name: _____

Work phone number:_____

Gender: M / F Number of children: _____

Who can we thank for recommending us? _____

Have you received chiropractic care before? Yes No

If Yes from whom? _____ When? _____

Details of the person responsible for the payment of fees:

Name: _____ Contac Number: _____

Please note all fees are payable at time of appointment.

Our Health

Your child's body is designed to be healthy. Throughout life, events can occur which may damage their health expression. This case history will help uncover those potential layers of damage, especially to your child's spine and nervous system, and determine how their health has been affected. Following an examination, a course of care will be outlined which will aim to restore normal spine function to help improve your child's ability to regulate themselves in their environment.

Child's first chiropractic visit

What concerns do you have regarding your child's health?

_____

_____

_____

Your pregnancy: Did you have (please tick)

- ☐ Difficulties conceiving
- ☐ Smoke or Drink
- ☐ Emotional upsets
- ☐ Healthy Diet
- ☐ Drugs / Medication
- ☐ Ultrasounds
- ☐ Miscarriages
- ☐ Caffeine
- ☐ Exercise
- ☐ Falls/ Accidents
- ☐ Morning sickness
- ☐ Amniocentesis / CVS

Birth details can give clues as to potential spinal problems.

Gestational duration _____

Was your child delivered normally? YES/NO (please tick)

- ☐ Posterior
- ☐ Forceps
- ☐ Assisted traction
- ☐ Breach
- ☐ Suction/ vacuum
- ☐ Multiple babies
- ☐ Induced
- ☐ Caesarean

Were any drugs used in the birth? _____

Was the birth difficult or long? YES/NO Duration of labour _____

Do you believe the birth was traumatic for your child? YES / NO

Apgar scores _____ Birth weight _____ Length _____

Was your child's head odd shaped at birth? YES / NO Bruised? YES / NO

Were there any complications? YES / NO

If YES (Provide details)

_____

_____

Incubation? How long? _____ Separation from mum? How long _____

Birth to six months: Was your baby:

- Breast Fed YES/NO for how long _____
- Difficulties breast feeding YES/NO
- Right or left breast fed evenly? YES/NO
- Formula fed? YES/NO
- From what age_____ for how long _____
- Was/is your baby 'colicky'? YES/NO ☐ mild ☐ moderate ☐ severe
- Did/does your child have reflux? YES/NO 'silent' reflux? YES/NO
- How does your baby sleep? ☐ poor ☐ fair ☐ good ☐ excellent
- Does your child have a preferred sleeping position YES/NO _____
- Did/does your baby move his or her bowels daily? YES/NO Easily? YES/NO
- Are you concerned about the shape of your baby's head? YES/NO
- Any vaccination reactions? YES/NO
- Post-natal depression in mother? YES/NO

Other problems: Is or has your child ever experienced (please circle)

Constipation	Diarrhoea	Hyperactivity	Attention difficulties	Social problems	Diagnosed ADHD
Concentration problems	Learning difficulties	Behavioural problems	Seem Un coordinated	Diagnosed ASD/Asperger's	Diagnosed Autism
Recurrent colds/flus	Ear Ache	Ear infection	Asthma	Allergies	Poor appetite
scoliosis	Lower back pain	Mid-back pain	Neck pain	Growing pain	Joint problems
Night terrors	headaches	sinus	convulsion	bedwetting	Clicky hip
Sleep prbs	Recurrent chest infxn	Recurrent tonsillitis	Chronic fatigue	Food intolerance	Exposure to smokers
Poor balance	Speech & language problems	Exercise tolerance			

When did your child roll? _____ Sit _____

Did your child crawl 'properly'? YES/NO What age? _____

When did your child walk? _____

Has your child been to hospital for any reason? _____

Has your child had any significant falls/accident? _____

Has your child broken any bones? _____

Does your child ever bang head repeatedly? _____

How many courses of antibiotics has your child had?

Last six months _____ during their life time _____

Has your child had other prescription medication? _____

Last six months _____ during their life time _____

Which vitamins and mineral supplements does your child have?

How would you describe your child's feeding habits?

Excellent ☐ Good ☐ Fair ☐ Poor ☐ Terrible ☐

How would you describe your child's emotional/mental health?

Excellent ☐ Good ☐ Fair ☐ Poor ☐ Terrible ☐

How would you describe your child's activity level (exercise, movement, play?)

Excellent ☐ Good ☐ Fair ☐ Poor ☐ Terrible ☐

Which activities?

Any family history of medical problems? YES/NO

Is there anything else you would like the chiropractor to know about your child or his/her family?

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Patient consent – Child

As a regulated health professional all chiropractors must warn patients of potential material risks associated with their treatment.

Published cases of serious adverse events in infants and children receiving chiropractic therapy are rare (2,3).

Chiropractors are trained to modify their treatment to suit the age and presentation of the child and special styles of very gentle treatment are used for babies and young children. A thorough history and examination is preformed to minimize any risk involved with the care provided and to determine if co-management or referral to another professional is warranted.

The most common complaints in infants and children after chiropractic treatment are stiffness or soreness, and restlessness or increased crying. These effects, if they occur, can be expected to last less than 24 hours following treatment.

If you have any questions relating to the treatment you or your child is to receive, please speak to the chiropractor.

I also acknowledge the personal information I provide will be treated confidentially by the practitioners and staff of this practise and that no external third party can access this information without my written consent.

I am parent / legal guardian of (child's name) _____

I understand I have had an opportunity to discuss the above information with the chiropractor and give my consent to examination and treatment.

Childs name _____

Parent/ Guardian's name: _____

Parent/Guardian's signature: _____ Date: __/ ____/ _____/

Chiropractors Name: _____

Chiropractors Signature: _____ Date: ___/ ____/ ____

1. Haavik, H. Murphy, B. Exploring the neuromodulatory effects of the verterbral subluxation and chiropractic care. CJA 40 (1) 2010
2. Vohra, S., et al., Adverse events associated with pediatric spinal manipulation: a systematic review. Pediatrics,2007.119(1):p. e275-83)
3. Todd, A. Carroll, M. Robinson, A. Mitchell, E. Adverse events in infants and children from chiropractic and other manual therapies JMPT 2014

Doctor's Notes: