

## 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: \_\_\_\_\_

Every child is gifted  
They just unwrap their packages at different times.

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?

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Your pregnancy: Did you have (please tick)

- |  |  |
|--|--|
| <input type="checkbox"/> Difficulties conceiving | <input type="checkbox"/> Miscarriages        |
| <input type="checkbox"/> Smoke or Drink          | <input type="checkbox"/> Caffeine            |
| <input type="checkbox"/> Emotional upsets        | <input type="checkbox"/> Exercise            |
| <input type="checkbox"/> Healthy Diet            | <input type="checkbox"/> Falls/ Accidents    |
| <input type="checkbox"/> Drugs / Medication      | <input type="checkbox"/> Morning sickness    |
| <input type="checkbox"/> Ultrasounds             | <input type="checkbox"/> Amniocentesis / CVS |

Birth details can give clues as to potential spinal problems.

Gestational duration \_\_\_\_\_

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

- |  |  |                                    |
|--|--|------------------------------------|
| <input type="checkbox"/> Posterior         | <input type="checkbox"/> Breach          | <input type="checkbox"/> Induced   |
| <input type="checkbox"/> Forceps           | <input type="checkbox"/> Suction/ vacuum | <input type="checkbox"/> Caesarean |
| <input type="checkbox"/> Assisted traction | <input type="checkbox"/> Multiple babies |                                    |

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)

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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

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- 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 Uncoordinated	Diagnosed ASD/Asperger's	Diagnosed Autism
Recurrent colds/flu	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 probs	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? \_\_\_\_\_

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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?

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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?

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Any family history of medical problems? YES/NO

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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 vertebral 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

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**Doctor's Notes:**

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