CONFIDENTIAL PATIENT INFORMATION (CHILD)

(For office use) **Date:** **Patient Code:**	**Cobham Chiropractic Centre** **Tel: 01932 988580** E-mail: reception@cobhamcc.co.uk www.cobhamcc.co.uk

Personal Information

Full name:	**Mr / Master / Miss** (please circle)
Address (including postcode):	
Home phone: (patient / mother / father / guardian) *delete as applicable	**Mobile phone:** (patient / mother / father / guardian)
Email address: (patient / mother / father / guardian)	
Date of birth:	**Age:**
Height (cm):	**Weight (kg):**
Parents / guardians names:	**Siblings names and ages:**

Who may we thank for referring you? _____

What Has Brought You Here (to be completed with or by parent/guardian)

Reasons for consultation:

Please list health concerns according to their severity	When did this start?	Has this happened before? When?	Did the problem begin with an injury? What type?
1.			
2.			
3.			
4.			

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐ Up and Down? ☐

What aggravates the condition (positions, movements, activities, etc)?

_____

_____

Other practitioners you have seen for this condition (please give names if known):

_____

_____

Please give details of whether or not these have helped:

_____

_____

General Health History

Any history of surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Any history of accidents and/or injuries: e.g. vehicle, bike, stairs, fall, fracture, sports?

1. Details:	When?	Hospitalized?
2. Details:	When?	Hospitalized?
3. Details:	When?	Hospitalized?

Have any x-rays ever been taken?

Area of body:	When?	Where?

Does your child have a preferred sleeping position? ◯ Yes ◯ No _____

Was/is child breast-fed? ◯ Yes ◯ No For how long? _____

Did/does your child prefer breast-feeding on one side? ◯ Yes ◯ No _____

Did your child frequently vomit after feeding? ◯ Yes ◯ No _____

Does your child have food allergies/intolerances? ◯ Yes ◯ No _____

Has your child been vaccinated? ◯ Yes ◯ No _____

Were there any negative reactions? ◯ Yes ◯ No _____

History of frequent infections? ◯ Yes ◯ No _____

If so, how many courses of antibiotics has your child received in their lifetime? _____

Does your child play sports? ◯ Yes ◯ No Hours per week?_____ _____

Is school backpack used? ◯ Yes ◯ No Weight of backpack? _____ kg/lbs

Approximate hours spent at play per week? _____

Average time spent at computer/TV/video games per week? _____ hrs

Does your child wear glasses or contact lenses? ◯ Yes ◯ No _____

Does your child have difficulty with coordination? ◯ Yes ◯ No _____

Current Medicines and Supplements
Please list any medications/drugs taken by the patient in the past 6 months and why:

_____

_____

Please list all nutritional supplements, vitamins, homeopathic remedies taken by the patient and why:

_____

_____

Pregnancy and Birth History

Gestational Duration: _____ weeks

Trauma/Falls during pregnancy? ◯ Yes ◯ No _____

Invasive Procedures (e.g. Amniocentesis) ◯ Yes ◯ No _____

During the pregnancy did the mother:

Smoke? ◯ Yes ◯ No How much? _____

Drink Alcohol? ◯ Yes ◯ No How much? _____

Take Medications? ◯ Yes ◯ No How much? _____

Use recreational Drugs? ◯ Yes ◯ No How much? _____

Fall ill? ◯ Yes ◯ No Please explain _____

Please rate your stress levels during pregnancy 1-10 (1= low, 10=high): _____

LABOUR

Was labour induced? ◯ Yes ◯ No

Duration of labour? _____

Duration of active (pushing stage) labour? _____

Did mother receive medications? E.g. Pain relief, epidural ◯ Yes ◯ No

If yes, please list: _____

BIRTH

Type of birth? ◯ Vaginal ◯ C-Section (Elective / Emergency?)

Presentation: ◯ Cephalic (head first) ◯: Breech ◯ Footling Breech (feet first)

Location of birth? ◯ Home ◯ Hospital ◯ Birthing centre

Birth Assistants? ◯ Midwife ◯ Doula ◯ Obstetrician

Was there any assistance needed during birth?

◯ Forceps ◯ Vacuum Extraction (Vonteuse) ◯ Assisted Traction/Head Turning

◯ Clavicle fracture ◯ Other _____

Please describe any other complications or procedures involved with the birth:

_____

_____

_____

Was there any evidence of birth trauma to the infant? Tick all that apply:

- ◯ Bruising
- ◯ Odd shaped head
- ◯ Stuck in birth canal
- ◯ Fast or excessively long birth
- ◯ Respiratory depression
- ◯ Cord around neck

Was your child subjected to any of the following?:

- ◯ Incubation — How long? _____
- ◯ Separation from mother — How long? _____

Did your child spend any time in intensive care? ◯ Yes ◯ No If yes, how long? _____

APGAR score at birth? _____ APGAR score at 5 minutes? _____

Birth Weight? _____ Birth Length? _____

GROWTH AND DEVELOPMENT

Was your child alert & responsive within 12 hours of delivery? ◯ Yes ◯ No

If no, please explain: _____

At what age did your child:

Sit unaided? _____ Crawl? _____

Walk? _____ Talk? _____

Do you consider their sleeping pattern normal? ◯ Yes ◯ No _____

Quality of Sleep? ◯ Good ◯ Fair ◯ Poor Number of hours _____

Any behaviour problems? ◯ Yes ◯ No _____

Do you feel that your child's social and emotional development is normal for their age? ◯ Yes ◯ No

_____

I consent to a professional and complete chiropractic examination and to any X-ray investigation that the chiropractor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Child (Patient) Name: _____

Parent / Guardian Name: _____

Parent / Guardian Signature: _____

Date: _____