Tasman Bay Chiropractic

Infant/Toddler Health History Form

Please complete all sections that are relevant to your child. Where the question is not age appropriate or not relevant, please indicate using "N/A"

CONFIDENTIAL

Child's Name _____

Parent(s) Name(s) _____

Sibling(s) Name(s) and Age(s) _____

Child's Age _____ Date of Birth / / Gender: Male/Female

Address _____

_____ Postcode _____

Home Phone: _____ Other Phone _____

*E-mail: _____

Is this an ACC Claim? Yes [ ] No [ ] Ethnicity _____ (for ACC)

Who is your child's regular doctor (General Practitioner)? _____

Has your child ever seen a chiropractor? Yes/No

If Yes - Who, and when? _____

If No - We will explain everything as we go and only proceed once you are completely comfortable.

Please circle the purpose for your child's visit: crisis management/early detection of problems/prevention/wellness/maximizing normal growth and development

Any other objectives for this visit?_____

Do you have any concerns for your child's health?

Primary _____

Secondary _____

*****_will be used to send our quarterly newsletter to and for correspondence regarding your child's care_

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Please tick if your child may have had any of the following:

reflux		frequent colds		constipation	
irritability		sinus congestion		diarrhoea	
fatigue		sore throats/swollen glands		urinary problems	
frequent loss of balance		ear pain/infections		bloating/gas	
loss of concentration		cold sweats		weight loss/gain	
poor co-ordination		difficulty breathing		dental problems	
reduced mobility		bronchitis		sleeping problems	
weakness		fevers		fainting	
vision changes		face flushed		Other, please comment	
light sensitivity		allergies			

Comments

_____

_____

_____

_____

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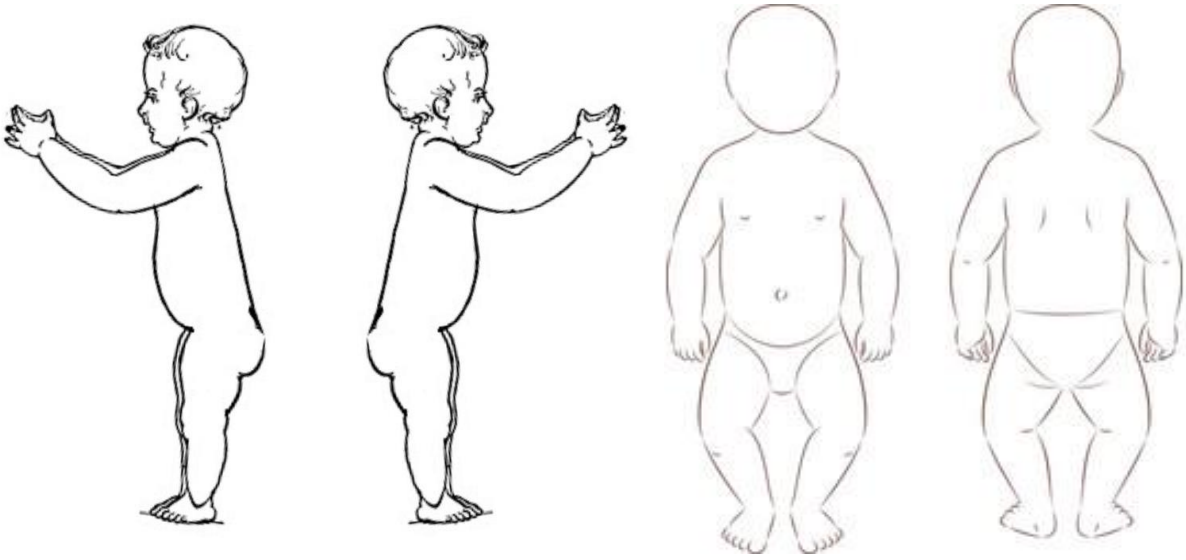
Where is the Problem?

If you know where your child may have a problem, please indicate on the diagrams below.



Birth History

What was the child's gestational age at birth? _____ weeks

Birth Weight _____ Birth Length _____

Where was your child born? At home/birthing centre/hospital/other _____

Was the birth considered medical/midwife? Duration of birth _____ hours

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? Yes/No

If no, please explain _____

At what age did the child: Respond to sound _____ Follow an object _____

Hold up head _____ Vocalise _____ Sit alone _____

Teethe _____ Crawl _____ Walk _____

Does your child sleep: front/back/side? How many hours per day? _____

Do you consider the child's sleeping pattern normal? Yes/No

If no, please explain _____

Family Health History

Please note any health problems (eg: cancer, hereditary conditions, diabetes, heart disease) that are present in:

Mother's family _____

Father's family _____

Sibling(s) _____

Stressors
Since problems that chiropractors look and detect can be related to many types of stressors, our chiropractor may ask some questions about stressors.

Authorising Consent for examination of a Minor (under 16 years)**:** Please Read Carefully

In order for the chiropractor to make a determination on the suitability of my child's/guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation.

I have had the opportunity to discuss with the chiropractor, or with any party authorised to do so by that chiropractor, the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the chiropractor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated to best practices delivered in the child's interest.

_____
(Signature)

_____
(Print Name)

_____
(Date)

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CONSULTATION AND EXAMINATION

H.H.

Lifestyle ☐ NTR

Radiation History ☐ NO ☐ YES

Previous Treatment ☐ NO ☐ YES

Supine

	L	R	L	R	L	R
Hip ROM						
C. Rot 70˚						
C. Flx 45˚						
C. Ext 45˚						
C. Lat 40˚						
T/L Flx 90˚						
T/L Ext 30˚						
Palmer 6m						
ATNR 6m						
Babinski 2y						
Kernigs						
Eye track						
Acstc blink						
Rooting 4m						
Moro 4m						
Traction						

Being Held

	L	R	L	R	L	R
Stepping 3m						
Placing 3m						
Landau 1y						
T/L Rot 10˚						

Prone

	L	R	L	R	L	R
Derifield						
Galants 9m						
Glutes						
AMSCT						

Internal	L	R	L	R	L	R
TMJ						
Upper Palate						

	P	
	T	
	M	
	C	
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	O	
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