Your ALLIED HEALTH CENTRE
chiropractic • acupuncture • massage • physiotherapy

Shop 9, Woolworths Marketplace
Cnr Old Northern Road &
Albany Forest Drive
Albany Creek
Q 4035

phone: 07 3325 0506
email: care@yahc.com.au
web site: www.yahc.com.au

Paediatric Case History

(0 to 13 years of age) *All information contained in this questionnaire is strictly confidential.*

Name:			**Date of Birth:**	
Address:				
Name/s of Parent/Guardians:				
Phone: (H)	(W)	(M)		
Email Address:				
Siblings Names & Ages:				
Are you a member of a health fund that pays for Chiropractic Care? ☐ Yes ☐ No ☐ Don't Know				
If Yes, please provide name of health fund:				
Who or what referred you to this Centre?				
Has your child ever had Chiropractic Care before? ☐ Yes ☐ No				
If Yes	Name of Chiropractor:		Located Where?	
When was your child's last visit?	Reason for Care?			
What were the results of the treatment? **Please ✓**				
☐ Excellent	☐ Satisfactory	☐ Fair	☐ Did not help	☐ Got worse
Did the Chiropractor take X-Rays? ☐ Yes ☐ No			Was your child examined thoroughly? ☐ Yes ☐ No	
Is there a family history of Scoliosis or other Spinal problems? If so, please describe:				

Previous and Current Health

Name of Paediatrician:	Located where?
Date of last visit:	Reason for last visit:
Reason for your child's visit:	
Has your child had any other serious health problems within the past 3 years? ☐ Yes ☐ No	
If Yes, please describe what and when:	
Has your child ever been in a motor vehicle accident, had any sporting injuries or major falls? ☐ Yes ☐ No	
Has your child ever been hospitalised or had any operations? ☐ Yes ☐ No	
If Yes, please describe what and when:	
List any broken bones, fractures, dislocations or sprain injuries your child has had and when:	

Vaccination and Medicinal History

Has your child been vaccinated? ☐ Yes ☐ No
How many doses of Antibiotics has your child taken: Past 6 months? Total in his/her lifetime?
How many doses of Prescription Medications has your child taken: Past 6 months? Total in his/her lifetime?
Please list medications:
Is your child currently taking any type of medication, drugs or vitamins? ☐ Yes ☐ No
If Yes, **Please ✓** ☐ Antibiotics ☐ Medication for any discomfort ☐ Muscle relaxants ☐ Anti-inflammatory ☐ Vitamins ☐ Anti-depressants ☐ Other:
For what condition/s is your child taking this medication?

Prenatal History

Name of Obstetrician/Midwife:

Complications during pregnancy? ☐ Yes ☐ No

Ultrasounds during pregnancy? ☐ Yes ☐ No How many:

Medication during pregnancy? ☐ Yes ☐ No

Cigarette/Alcohol use during pregnancy: ☐ Yes ☐ No Location of birth: ☐ Home ☐ Hospital ☐ Birth Centre

Type of birth: ☐ Vaginal ☐ C-Section ☐ Planned induction ☐ Emergency ☐ Forceps ☐ Suction/Vacuum Extraction

☐ Normal ☐ Breech ☐ Posterior ☐ At term ☐ Premature ☐ Overdue

Any complications during surgery? ☐ Yes ☐ No		Any Genetic disorders or disabilities? ☐ Yes ☐ No
Birth weight:	Birth length:	APGAR scores:

Was your child's head mis-shapen at birth? ☐ Yes ☐ No

Feeding History

Breast fed: ☐ Yes ☐ No If Yes, for how long:

Formula fed: ☐ Yes ☐ No If Yes, for Introduced to: Solids ____months Cows milk ____months

Food/juice allergies or intolerances: ☐ Yes ☐ No	If Yes, please describe:

Has your child ever had any of the following?

☐ ADHD	☐ Chronic colds	☐ Eczema/Psoriasis	☐ Measles	☐ Recurring tonsillitis
☐ Allergies	☐ Colic/Reflux	☐ Falls head first from high places	☐ Mumps	☐ Scoliosis
☐ Appendicitis	☐ Constipation/Diarrhoea	☐ Growing/Back Discomfort	☐ Poor coordination	☐ Seizures/Epilepsy
☐ Asthma	☐ Developmental disorders	☐ Headaches	☐ Poor sleeping habits	☐ Social disorders
☐ Bed wetting	☐ Digestive problems	☐ Juvenile Diabetes	☐ Pneumonia	☐ Travel sickness
☐ Chicken Pox	☐ Ear infections	☐ Learning disorders	☐ Recurring fevers	☐ Whooping cough

Other:

What are your child's habits

Has your child been in any of the following high impact or contact sports?

☐ Soccer ☐ Football ☐ Gymnastics ☐ Karate ☐ Hockey ☐ Basketball ☐ Softball ☐ Dance ☐ Other

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life.

Was this the case for your child? ☐ Yes ☐ No

Had falls from:	☐ Bed	☐ Down stairs	☐ Off swings	☐ Change table	☐ Out of trees	☐ Off bike	Total number of falls:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for the prevention and early detection of vertebral subluxation (spinal nerve interference).

Developmental History

At what age was your child able to:

Respond to sound:	Respond to visual stimuli:	Hold head up:	Sit up alone:
Cross crawl:	Stand alone:	Walk alone:	

Posture is the window to the spine. Abnormal or bad posture contributes to spinal stress and may lead to vertebral subluxation. Vertebral subluxations can severely inhibit the ability of the Nervous System to function at its optimum.

Does your child often slump or sit with rounded back and shoulders? ☐ Yes ☐ No

Does your child wear his/her backpack on both shoulders? ☐ Yes ☐ No

How many hours per day does you child spend in front of the: Television: Computer:

What position does your child sleep in at night? ☐ Side ☐ Back ☐ Stomach ☐ All

PLEASE READ AND SIGN

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient's/Guardian's Signature:	**Date:**