Welcome

MMC
Mid-Murray Chiropractic

Today's date

Confidential Case History 13 – 18 years

Who are we helping today?

Child's Name | Date of birth | Age | boy | girl

Child's Postal Address

Who is responsible for the child's care?

Who do we contact in relation to appointments and follow up care?

Carer's Name | Relationship to child

Mobile | A/H

Email

Who can we thank for referring you? Referred by

Has your child ever received chiropractic care? yes no | If YES, when did they first visit a chiropractor?

What was the reason? | How often were they adjusted?

When was your child's last adjustment? | Did you see results from care provided?

Please rate your overall experience of that care? [Exceeded expectations] 5 4 3 2 1 [Disappointed]

Please rate your overall experience of chiropractic in general? [Exceeded expectations] 5 4 3 2 1 [Disappointed]

How can we help your child today?

(Please tick) Have you been referred to us for a **specific reason** or a **chiropractic health check-up**?

If it is for a specific reason, please explain further

How long has it been an issue?

Do you feel that it is: Getting Better | Staying the same | Getting worse | Unsure

If no, please explain

Please tick if you have concerns about the following

Moods / Reactions	Headaches	Poor Posture	Learning Difficulties
Sleep Problems	Poor Neck Movement / Position	Co-Ordination & Balance	(Females) Period Pains
Asthma	Hip / Leg / Knee / Foot	Scoliosis / Curvature of the Spine	Digestion

Any other concerns that are not listed above?

Is your child currently under the care of another health professional? Yes No

Is your child currently on any medication, vitamins, minerals, herbs etc? Yes No

Pregnancy History

You might be wondering why we need to know about the mother's health and her pregnancy. We believe that the future health of a child begins prior to conception and throughout pregnancy. The mother's lifestyle during pregnancy creates an imprint on the baby's growing mind and body. This includes the mother's diet, exercise and emotions. It's helpful for us to collect this information to understand your child's growth, development and health. Please tick, rate and explain the answer where appropriate.

Sleep, moods, thought patterns and stress can play a major role in hormone fluctuations, rest, repair and growth

What were the mother's average stress levels during the pregnancy? (work & home)

Low 1 2 3 4 5 High

Was conception assisted? eg. IVF N Y

Did she feel supported by family & friends?

No 1 2 3 4 5 Yes

What number full term pregnancy was this child?

Activity levels, posture, physical stress and accidents can impact foetal positioning, development and labour outcomes

The mother's exercise level during pregnancy? (3 x a week = 3)

None 1 2 3 4 5 Higher

Any accidents, falls or car accidents?

no yes

How long did she sit per day? (work + home)

<4hrs | 4-6hrs | 7-10hrs | 11-14hrs | 15+hrs

The nutrition quality, medicine/drug use and environmental exposures affect the wiring of a babies immune system

The' mother's vegetable consumption during the pregnancy? (Rate 3 for four serves/day)

Lower 1 2 3 4 5 Higher

Vaccines during pregnancy?

no yes

Please add details about the mother's health or allergies? | Mother's family history?

Please add details about the father's health or allergies? | Father's family history?

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Birth History

Being born is a big deal. Your child's birthing experience impacts their body's activation and initial acclimatisation to the world outside the womb. This may provide possible explanations for some of their initial symptoms and behaviour .

Fear and exhaustion interrupt the body's normal labour progression

What was the mother's level of exhaustion?
Low ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 High

Any blood pressure issues for the mother?
◯ no ◯ yes

Most interventions cause a great deal of stress on a child's body, head and neck.

Child position during labour?
◯ Head down ◯ Brow ◯ Breech ◯ Posterior

Were any of the following interventions used?
◯ Forceps ◯ Vacuum ◯ Forceful pulling

Drugs used during labour can cross the placenta and affect your baby

Were any of the following drugs used?
◯ Oxytocin ◯ Spinal Anesthesia ◯ Epidural ◯ Spinal Block ◯ Gas

Rate your child's alertness after birth?
◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 Alert

Please describe your child's birth. Please list any other medical interventions or drugs used

Was your child born ◯ **Vaginally** ◯ **Emergency C-Section** ◯ **Planned C-Section**?

Did your child experience foetal distress during labour? ◯ no ◯ yes Did your child need intensive care or resuscitation? ◯ no ◯ yes

After birth we identify signs of possible upper neck, spinal cord and head trauma from their appearance & history. Did your child have:

◯ Face bruising ◯ Odd head shape ◯ Blood shot eyes ◯ Swelling ◯ Cone head shape ◯ Jaundice

Health History During The First 2 Months

This information tells us about your child's first few weeks. Every newborn relies on involuntary in-built reflexes to feed, react to loud noises and lights, sleep, waking and calling for help. These reflexes are produced by the nervous system and are the same for every child. If reflexes are altered, we know the nervous system has been upset during pregnancy, birth or after. This impacts future growth and development and must be addressed. Please tick, rate and explain the answer where appropriate.

Sleep, moods, thoughts & emotional stress

Did the child recover well after birth?
◯ no ◯ yes

Did your child wake itself to feed?
◯ no ◯ yes

0 - 14 days how long was their sleep?
◯ <1hr block ◯ 1-2 hrs ◯ 2-3 hrs ◯ 3+hr blocks

Development, posture, activity levels & physical stress

What was your child's muscle tone like?
◯ Floppy ◯ Average ◯ Stiff ◯ Tight

Did they have certain postural habits while sleeping or when they were awake?
◯ no ◯ yes

Nutrition, environment & immune system function

What was your child's first milk (0-6wks)?
◯ Breast Milk ◯ Formula ◯ Both

Experience colic, reflux or persistent crying?
◯ no ◯ yes

Did your child have to take any medicines?
◯ no ◯ yes

Any further details to add about the first 2 months of life?

Health History From 2 Months To 12 Months

After the first 6-8 weeks we find that some families start to get into routines and tend to get out and about a little more. During the first year of life a child's body and brain is growing rapidly from learning from the world around them. Understanding what their environment was like, how they reacted and coped, their milestones and health history, gives us information about their nervous systems health and development.

Sleep, moods, thoughts & emotional stress

Did your child engage with eye contact
◯ no ◯ yes

Did your child frequently bang their head on furniture?
◯ no ◯ yes

Did your child have quick changes in temperament?
◯ no ◯ yes

Development, posture, activity levels & physical stress

Did your child like tummy time?
◯ no ◯ yes

Did your child reach their milestones at similar times to their peers?
◯ no ◯ yes

Has your child fallen from a high chair, table or couch? Or bumped their head firmly?
◯ no ◯ yes

Nutrition, environment & immune system function

What did your child predominately drink/eat from 2 months?
◯ Breast Milk ◯ Formula ◯ Both

Experience ear infections or tonsillitis?
◯ no ◯ yes

Experience skin rashes, eczema or dermatitis?
◯ no ◯ yes

Persistent colds and flus (> than 2/yr)
◯ no ◯ yes

Development & Movement

When did they begin to use words?

When did your child start to sit on their own?

Did they have difficulty crawling properly?

When did they begin to walk?

Did they smile readily?

Do you have any other details you feel we should know?

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Health History From 1 And Above

What childhood illnesses has your child experienced? ◯ Measles ◯ Mumps ◯ Chicken Pox ◯ Glandular Fever

Any other childhood illnesses?

What medications/antibiotics have been used, for what conditions and how frequently?

Any hospitalisations or hospital visits? ◯ no ◯ yes Details:

Has your child received the standard vaccinations? ◯ no ◯ yes Any alterations to the schedule?

Any reactions to their vaccinations? ◯ no ◯ yes Details:

Sleep, moods, thoughts & emotional stress			Development, posture, activity levels & physical stress			Nutrition, environment & immune system function		
Sleeping problems	◯ no	◯ yes	Balance problems	◯ no	◯ yes	Chronic Colds/Flu (>4 x per year)	◯ no	◯ yes
Hard to wake or very tired	◯ no	◯ yes	Problem walking	◯ no	◯ yes	Ear infection or tonsillitis	◯ no	◯ yes
Fatigue	◯ no	◯ yes	Clumsy / often trips/falls	◯ no	◯ yes	Fever in the last 2 weeks	◯ no	◯ yes
Temper / Tantrums	◯ no	◯ yes	Scoliosis	◯ no	◯ yes	Upper respiratory infections	◯ no	◯ yes
Quick mood changes	◯ no	◯ yes	Back or neck pain	◯ no	◯ yes	Allergies	◯ no	◯ yes
Gets frustrated easily	◯ no	◯ yes	Other body pains (arms, legs)	◯ no	◯ yes	Dark circles under eyes	◯ no	◯ yes
Does not cope well with stress	◯ no	◯ yes	Major fall / injury	◯ no	◯ yes	Eczema	◯ no	◯ yes
Anxiousness / Anxiety	◯ no	◯ yes	Bed Wetting	◯ no	◯ yes	Asthma	◯ no	◯ yes
ADHD / Autism	◯ no	◯ yes	Motion Sickness	◯ no	◯ yes	Food Intolerances and sensitivities	◯ no	◯ yes
Head banging	◯ no	◯ yes	Learning difficulties	◯ no	◯ yes	Diarrhoea / Constipation	◯ no	◯ yes
Shys away from loud sounds, textures, certain situations	◯ no	◯ yes	Occulo-motor problems	◯ no	◯ yes			

Do you have any further concerns about your child's health, growth or development?

How Your Child Uses Their Body

Which HAND, FOOT, EYE OR EAR does your child use for the following activities;

Drawing & Writing	◯ Right	◯ Left	◯ Both	Dominant Eye	◯ Right	◯ Left	◯ Both	Kicking	◯ Right	◯ Left	◯ Both
Throwing	◯ Right	◯ Left	◯ Both	Dominant Ear	◯ Right	◯ Left	◯ Both	Hopping	◯ Right	◯ Left	◯ Both

How your child's body and brain communicates…

Doesn't like to OR can't sit still for short periods ◯ no ◯ yes

Difficulty learning to ride a bike ◯ no ◯ yes

Hesitant of stairs ◯ no ◯ yes

Avoids activities with movement or balance ◯ no ◯ yes

Loves swings & spinning ◯ no ◯ yes

Difficulty learning to skip ◯ no ◯ yes

How your child uses their body in space and interacts with the world…

Frequently drops things	◯ no	◯ yes	Avoids / dislikes chewy foods	◯ no	◯ yes
Walks on toes frequently	◯ no	◯ yes	Accidently breaks crayons often	◯ no	◯ yes
Does not like closing eyes for tasks	◯ no	◯ yes	Writes with tongue hanging out	◯ no	◯ yes
Must sleep with light on	◯ no	◯ yes	Likes heavy blankets	◯ no	◯ yes
Confuses right and left	◯ no	◯ yes	Weaker or tires easily compared to others	◯ no	◯ yes
Poor posture or slumps in chairs	◯ no	◯ yes	Difficulty with buttons & laces	◯ no	◯ yes
Difficult dancer, skipper or hopper	◯ no	◯ yes	Breaks items easily	◯ no	◯ yes
Frequently walking into furniture and doorways	◯ no	◯ yes			

If your child is at school...

Does your child have difficulty, or are below average for their age, with the following:

◯ Reading	◯ Spelling	◯ Sleep	◯ Organisation	◯ Sport
◯ Math	◯ Handwriting	◯ Following directions	◯ Remembering information	◯ Homework completion

Do they have any other learning concerns?

How much does this affect them?

Thank you for your time and detailed responses!

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To be completed by the teenager

Kid's Questionnaire Age 13 +

Your health is so important. When you are healthy you are able to enjoy life and live, move and play at your best. It is our job as chiropractors to understand how well your body is working and how healthy you are overall so we can look after you properly.

Please read each question and tick response that suits you best this **month.**

Energy, vitality & resilience	Never	Almost never	Sometimes	Often	Almost always
I am full of energy when I wake up in the mornings	○	○	○	○	○
I have good energy all day	○	○	○	○	○
I can think easily when I wake up	○	○	○	○	○
I have energy at the end of the school day	○	○	○	○	○
I had a really good month	○	○	○	○	○
I think my health will be good in the future	○	○	○	○	○
I feel my body is strong and healthy	○	○	○	○	○

Sleep, moods, thoughts and emotional stress	Never	Almost never	Sometimes	Often	Almost always
I fall asleep easily at night	○	○	○	○	○
I sleep through the whole night each night	○	○	○	○	○
It is easy to wake up in the morning	○	○	○	○	○
I needed extra rest this month	○	○	○	○	○
I feel happy	○	○	○	○	○
I think good things happen to me	○	○	○	○	○
I feel good about myself	○	○	○	○	○
I tell my parents how I am feeling	○	○	○	○	○
I can set a goal and work towards it	○	○	○	○	○
I am well behaved & get along with others	○	○	○	○	○
I can focus and complete school work easily	○	○	○	○	○
I can easily follow directions	○	○	○	○	○
I make friends easily	○	○	○	○	○
I find it easy to pay attention in school	○	○	○	○	○
I like school	○	○	○	○	○
I get angry easily	○	○	○	○	○
I worry about things a lot	○	○	○	○	○

Development, posture, activity levels & physical stress	Never	Almost never	Sometimes	Often	Almost always
I can move around easily	○	○	○	○	○
I have good co-ordination with sports and movement	○	○	○	○	○
I am steady on my feet	○	○	○	○	○
I find it easy to stand up tall and have good posture	○	○	○	○	○
I get outdoors and play sport each month	○	○	○	○	○
I have lots of accidents, falls or run into things easily	○	○	○	○	○
I get tired easily	○	○	○	○	○
I am in pain, something hurts	○	○	○	○	○
I took medication for pain	○	○	○	○	○
I got sick	○	○	○	○	○

Nutrition, environment & immune system function	Never	Almost never	Sometimes	Often	Almost always
I ate vegetables every day	○	○	○	○	○
I drink a bottle of water or more at school	○	○	○	○	○
My body is healthy	○	○	○	○	○
My immune system is strong	○	○	○	○	○
I had allergies	○	○	○	○	○
I had a cold	○	○	○	○	○
I had tummy aches	○	○	○	○	○
I was constipated or had diarrhoea	○	○	○	○	○

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