Welcome

Confidential Case History

Mid-Murray Chiropractic

Today's date

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 Carer's Name

Relationship to child Relationship to child

Mobile Mobile

A/H A/H

Email 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

Do you feel that your child is developing and reaching their milestones in a similar time to their peers? ◯ Yes ◯ No

If no, please explain

Please tick if you have concerns about the following

◯ Moods / Reactions ◯ Head Shape Asymmetry ◯ Poor Posture ◯ Learning Difficulties

◯ Sleep Problems ◯ Poor Neck Movement/Position ◯ Co-Ordination & Balance ◯ Achieving Certain Milestones

◯ Muscle Tone ◯ Hip / Leg / Knee / Foot ◯ Crawling / Walking ◯ Digestion / Feeding

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

Consent for examination and chiropractic care of a young person

For your Chiropractor to determine the appropriate care for your child a thorough examination must be completed. By signing this form you o grant permission for the chiropractor to:

- Gather all appropriate information about this child, their gestation, birth and health history
- Perform a full examination with chiropractic, orthopaedic and neurological tests
- Provide a Well Kids care plan and chiropractic adjustments where appropriate

By signing below I understand and agree with the following statements

- The information provided is accurate and all inclusive and will remain confidential
- I am able to ask questions and discuss both the examination process, procedures and following report in detail

The Risks & Current Research About Chiropractic Care For Kids

As with any health care examination and treatment there is a risk of the condition changing. Current (2009) research from the International Chiropractic Pediatric Association demonstrated chiropractic care is very safe and effective for kids. The research of 5,438 chiropractic visits, 577 children, showed parents indicated only two children (<1%) experienced minor discomfort after an adjustment, which readily resolved with continued chiropractic care. The research showed both parents and doctors indicated a high rate of improvement with respect to the children's presenting complaints. Parents also reported better sleeping patterns, improvements in behaviour and, improved immune system function while under chiropractic care.

Carer's signature Name printed

Chiropractor's signature

Well Kids

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 click, 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 mothers average stress levels during the pregnancy? (work & home)
Low ◯1 ◯2 ◯3 ◯4 ◯5 High

Was IVF used to conceive? ◯no ◯yes

Rate the mothers level of fear about labour?
None ◯1 ◯2 ◯3 ◯4 ◯5 High

Rate emotional stress? e.g. lost loved one
Low ◯1 ◯2 ◯3 ◯4 ◯5 High

Rate depression levels experienced?
Low ◯1 ◯2 ◯3 ◯4 ◯5 High

Rate anxiety levels experienced?
Low ◯1 ◯2 ◯3 ◯4 ◯5 High

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 mothers exercise level during pregnancy? (3 x a week = 3)
None ◯1 ◯2 ◯3 ◯4 ◯5 Higher

Any accidents, falls or car accidents?
◯no ◯yes _____

Experience back pain?
None ◯1 ◯2 ◯3 ◯4 ◯5 High

Participate in pregnancy yoga or similar?
◯no ◯yes _____

How long did she sit per day? (work + home)
◯<4hrs ◯4-6hrs ◯7-10hrs ◯11-14hrs ◯15+hrs

Participate in 'jolting' sports? e.g. netball
◯no ◯yes _____

Participate in a physical or active job?
◯no ◯yes _____

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

The mothers' vegetable consumption during the pregnancy? (Rate 3 for four serves/day)
Lower ◯1 ◯2 ◯3 ◯4 ◯5 Higher

Morning sickness?
None ◯1 ◯2 ◯3 ◯4 ◯5 High

Cravings OR Avoidances?
◯no ◯yes _____

Vaccines during pregnancy?
◯no ◯yes _____

Cigarette use or exposure? (Daily = HIGH)
None ◯1 ◯2 ◯3 ◯4 ◯5 High

Alcohol exposure? (Daily = HIGH)
None ◯1 ◯2 ◯3 ◯4 ◯5 High

Drug exposure? (Daily = HIGH)
None ◯1 ◯2 ◯3 ◯4 ◯5 High

Please add details about the mothers health or allergies? _____

Mothers family history? _____

Rate the fathers stress levels at the time of conception? (work & home)
Low ◯1 ◯2 ◯3 ◯4 ◯5 High

Did he experience depression or anxiety?
◯no ◯yes _____

Rate the fathers exercise level prior to conception? (3 x a week = 3)
None ◯1 ◯2 ◯3 ◯4 ◯5 or more

Has he had many x-rays, radiation or chemotherapy in the past?
◯no ◯yes _____

Rate the fathers vegetable consumption prior to conception? (3 = 4 serves a day)
Lower ◯1 ◯2 ◯3 ◯4 ◯5 or more

In the 2 mths prior to conception, did he use cigarettes, alcohol, drugs or medicines?
◯no ◯yes _____

Please add details about the fathers health or allergies? _____

Fathers family history? _____

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

Was/were the following interventions used?
◯Forceps ◯Vacuum ◯Forceful pulling

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

Was/were 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**?

Was the location of labour your intended location? ◯no ◯yes Was a doula present at your child's birth? ◯no ◯yes

Birth weight? _____ lbs/kg Birth length? _____ cm Head circumference _____ cm Weeks gestation? _____

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

Did your child cry immediately? ◯no ◯yes Did your child have an APGAR score less than 8? ◯no ◯yes why? _____

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

How many hours was the mother in active labour (pushing)? _____ If your child was born via C-section, was your child low in the pelvis and engaged beforehand (longer than 3 wks)? ◯no ◯yes

If your child was born in hospital, how long did they stay in? _____

Health History During The First 6-8 Weeks

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

Do you feel your child slept well post birth?
◯ no ◯ yes

Was skin-to-skin achieved after birth?
◯ no ◯ yes

Did the mother need medical support after labour?
◯ 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 your child arch their head or back?
◯ no ◯ yes

Did your child hold their head or back in a particular way?
◯ no ◯ yes

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

Does your child cry when changing posture?
◯ no ◯ yes

Was your child diagnosed with clicky hips?
◯ 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

Were Vit K or a vaccine given at birth?
◯ no ◯ yes

Were there smokers in the immediate family who held and took care of your child?
◯ no ◯ yes

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

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

Experience constipation or lots of gas?
◯ 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 the mother experience any post-natal depression?
◯ no ◯ yes

Did your child have difficulty sleeping?
◯ no ◯ yes

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

Did your child prefer to play by themselves than with others?
◯ no ◯ yes

Development, posture, activity levels & physical stress

When out and about what item did you predominately use?
◯ Pram ◯ Sling ◯ Baby Carrier ◯ Arms

Did your child like tummy time?
◯ no ◯ yes

Did they do >20 mins / day of 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

Has your child been in a car accident or near miss?
◯ 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

Did your child experience fevers of 39+?
◯ no ◯ yes

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

Experience colic, reflux, persistent crying, lots of gas or tummy distension?
◯ no ◯ yes

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

Details?

Who were my regular caregivers? ◯ Mum/Dad ◯ Family Members ◯ Regular Babysitter ◯ Friend ◯ Child Care

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?

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

Health History During From 1 To 12 Years

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

Sleeping problems	◯ no	◯ yes
Hard to wake or very tired	◯ no	◯ yes
Fatigue	◯ no	◯ yes
Temper / Tantrums	◯ no	◯ yes
Quick mood changes	◯ no	◯ yes
Gets frustrated easily	◯ no	◯ yes
Does not cope well with stress	◯ no	◯ yes
Anxiousness	◯ no	◯ yes
ADHD / Autism	◯ no	◯ yes
Head banging	◯ no	◯ yes
Shys away from loud sounds, textures, certain situations	◯ no	◯ yes

Development, posture, activity levels & physical stress

Balance problems	◯ no	◯ yes
Problem walking	◯ no	◯ yes
Clumsy / often trips/falls	◯ no	◯ yes
Scoliosis	◯ no	◯ yes
Back or neck pain	◯ no	◯ yes
Other body pains (arms, legs)	◯ no	◯ yes
Major fall / injury	◯ no	◯ yes
Bed Wetting	◯ no	◯ yes
Motion Sickness	◯ no	◯ yes
Learning difficulties	◯ no	◯ yes
Occulo-motor problems	◯ no	◯ yes

Nutrition, environment & immune system function

Chronic Colds/Flu (>4 x per year)	◯ no	◯ yes
Ear Infection or Tonsillitis	◯ no	◯ yes
Fever in the last 2 weeks	◯ no	◯ yes
Upper respiratory infections	◯ no	◯ yes
Allergies	◯ no	◯ yes
Dark circles under eyes	◯ no	◯ yes
Eczema	◯ no	◯ yes
Asthma	◯ no	◯ yes
Food Intolerances and sensitivities	◯ no	◯ yes
Diarrhoea / Constipation	◯ no	◯ yes

Do you have any further concerns about your childs 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	Avoids activities with movement or balance	◯ no	◯ yes
Difficulty learning to ride a bike	◯ no	◯ yes	Loves swings & spinning	◯ no	◯ yes
Hesitant of stairs	◯ 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 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!