Child's Name: _____ Date: _____

Australian Chiropractic College

Child Health History Form 0-5 years

Today's Date:_____ Date of Birth: _____ Age: _____ Gender: M / F

What is the main reason for today's visit:

_____

_____

_____

The following questions are designed to help us give the best possible care to your child.

Pregnancy

During your pregnancy did you have any of the following? *If yes, please give details.*

	Yes	No	
Falls			
Motor vehicle accidents			
High BP			
Diabetes			
Anaemia			
Morning sickness			
Indigestion			
Seizures			
Swollen ankles			
Thyroid problems			
Heart problems			
Back pain			
Abnormal bleeding			
Were you hospitalised			
Other illnesses			

During your pregnancy did you use any of the following?

	Yes	No	*If yes, please give details*
Tobacco			
Alcohol			
Non-prescribed drugs			
Diabetes			
Over-the-counter medication			

Labour and birth

How long was the labour from first contractions to the birth? _____hours

How long was the second phase (pushing phase) of the labour?_____Hours

	Yes	No
Hospital birth		
Home Birth		
Midwife assisted		
Obstetrician assisted		
Vaginal Delivery		
Planned C-section		

	Yes	No
Forceps		
Vacuum extraction		
Anaesthesia		
Foetal distress		
Meconium staining		
Emergency C-section		

	Yes	No
Breech		
Induced		
Head presentation		
Face presentation		

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Neonate Condition

Apgar Scores: 1 minute _____/10 5 minutes _____/10

Intensive care ☐ Yes ☐ No Days in intensive care unit _____

Birth weight _____lbs/kgs Birth length _____cms Baby home on day _____

Medication given at birth _____

Vaccines administered_____

Sleep

How many hours does your child sleep? During the day?_____At night?_____

	Yes	No	*If yes, please give details*
Do they have a preferred sleeping position?			
Do they go to sleep easily?			
Is sleep often disturbed?			

Nutrition

	Yes	No	*If yes, please give details*
Is your child still being breastfed?			
If yes, do they have a one-sided preference?	☐ Left	☐ Right	
If no, for how long were they breastfed			
Is your child formula fed?			
Does your baby spit up after feeding?			
Is your child eating solid food?			
Does your child have any feeding difficulties?			
Does you child have any digestive disturbances?			
Does your child have any skin rashes			
Is your child taking vitamins or supplements?			

What does your child normally eat for breakfast? _____

What does your child normally eat for lunch? _____

What does your child normally eat for dinner? _____

What does your child normally eat for snacks? _____

What is your child's favourite food? _____

What types of fast food does your child like to eat? _____

How often does your child eat fast food? _____

Trauma

	Yes	No	*If yes, please give details*
Has your child had any falls or trauma?			
Has your child been in a car accident or near miss?			
Has your child ever had a broken bone?			

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Health History

	Yes	No	*If yes, please give details*
Has your child ever had colic*?			
Has your child ever had upper respiratory infections? How often?			
Has your child had asthma?			
Has your child ever had any antibiotics?			
Does your child ever complain of pain or discomfort? Where?			

**Is it difficult to settle your child/are they often upset?*

Does your child ever specifically complain of pain in the following areas?

	Yes	**No**	*If yes, please give details*
Back			
Neck			
Arms			
Legs			
Ears			
Head			
Hands			
Feet			

General Health

	Yes	**No**	*If yes, please give details*
Is your child allergic to anything?			
Are there smokers in the child's home?			
Is your child currently receiving any medications?			
Has your child ever been to an emergency room?			
Does your child have a preferred head position?			
Has your child ever had a fever or illness?			
Has your child been vaccinated?			
Does your child frequently arch their head and body backwards?			
Has your child had any ear infections?			If yes, when was the first one? How frequently do they occur?

Do you have any other concerns?

Child's Name: _____ Date: _____

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FOR INTERNS USE ONLY *Most pertinent DDX's (H: hallmark, E: exam to R/I or R/O)*
1:
H:
E:
2:
H:
E:
3:
H:
E:
4:
H:
E:
5:
H:
E:
6:
H:
E:
7
H:
E:
8:
H:
E:

HISTORY REVIEW

Intern Name: _____

_____

Intern Signature Date

Chiropractic Mentor Name: _____

_____

Chiropractic Mentor Signature Date