Child's Name: _____ Date: _____

Australian Chiropractic College

Child Health History Form 6 - 12 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? _____

	Yes	No	*If yes, please give details*
Do they have a preferred sleeping position?			
Do they go to sleep easily?			
Is sleep often disturbed?			
Does your child often feel exhausted by the end of the week?			

Nutrition

	Yes	No	*If yes, please give details*
Was your child breastfed?			
Was your child formula fed?			
Did your baby spit up after feeding?			
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

Please tick all that apply:

- ○ Tripped over and fell forward
- ○ Slipped and fell onto buttocks
- ○ Fell off a bike
- ○ Fell of a bed
- ○ Fell off a change table
- ○ Light scrapes on hands / knees
- ○ Deep cuts on hands/knees
- ○ Hit head
- ○ Fell from a tree
- ○ Passenger in car accident
- ○ Passenger in a near miss
- ○ Hit with toys (swords, balls, bats etc)
- ○ Ever had a broken bone
- ○ Had a sporting injury

Please supply details to those applicable: _____

_____

_____

Child's Name: _____ Date: _____

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Health History

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

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 wet the bed?			
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?

Schooling

What year is your child in at school? _____
What school do you go to? _____
What subjects do you enjoy at school? _____
How do you carry your school books or bag? _____
How heavy is your school bag? _____
What sports do you play? _____
What are your hobbies? _____
How many hours each day do you watch TV? _____
How many hours each day do you use a computer? _____
How often do you play video games? _____
Do you ever feel upset or nervous at school? _____
Do you ever get headaches when you read? _____
Do you ever have difficulty seeing the board? _____

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Do you have any other concerns?

_____

_____

_____

_____

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

Intern Initials: _____ Chiropractic Mentor Initials: _____