LIFECARE CHIROPRACTIC

Confidential Infant (0-2)

Please carefully complete this questionnaire. Your answers will help us determine if Chiropractic care is appropriate for your child. They also help us devise the most effective treatment plan for your child. We only accept patients we sincerely believe we are able to help. Appropriate referrals are made where necessary. Thank you.

NAME _____

AGE _____ DOB _____ SEX M / F

ADDRESS _____

HOME PHONE _____MOBILE PHONE _____

MOTHER'S NAME_____FATHER'S NAME _____

CHIEF CONCERN OR CHECK UP_____

_____

OTHER CONCERNS _____

GP DETAILS _____

DATE OF LAST VISIT _____

PRENATAL HISTORY

AGE OF MOTHER AT BIRTH _____ PREVIOUS PREGNANCIES _____ NUMBER OF SIBLINGS _____

DURATION OF PREGNANCY _____WKS

MATERNAL HEALTH (please tick if you had any of the following during pregnancy)

- ☐ Hypertension
- ☐ Protienuria (blood in urine)
- ☐ Infection
- ☐ Major stressful episodes
- ☐ Blood glucose (gestational diabetes)
- ☐ Medication
- ☐ Drug use (including alcohol, caffeine, cigarettes etc)
- ☐ Illness
- ☐ X-Rays or Ultrasound taken
- ☐ Other_____

PLACE OF BIRTH: Hospital _____ Home _____ Birth Center _____Midwife_____

TYPE OF DELIVERY: Vaginal _____ Cesarean _____

HEALTH, GROWTH AND POSITIONAL ISSUES OF BABY WHILST PREGNANT

LENGTH OF LABOUR (when contractions are < /=10 min apart) _____

PLEASE TICK IF ANY OF THE FOLLOWING WHERE USED DURING LABOUR

☐ Induction ☐ Forceps ☐ Suction ☐ Epidural ☐ Membrane artificially ruptured

☐ Medication (please specify type)_____

PRESENTATION OF BABY AT BIRTH (breech, occiput anterior, occiput posterior, brow etc)
_____

NEONATAL (NEWBORN) HISTORY

WAS THE CHILD GIVEN DIRECTLY TO THE MOTHER? Y or N NEED FOR RESUSCITATION OR RESPIRATOR? Y or N

APGAR SCORE: 1min_____ 5min_____ LENGTH OF HOSPITAL STAY:_____

WAS THERE ANY JAUNDIC PRESENT? Y or N MEDICATION USED? _____

FEEDING

DID THE CHILD FEED SPONTANEOUSLY? Y or N DOES YOUR BABY HAVE A PREFERED FEEDING SIDE? Y or N _____

TYPE: ☐ Breast only ☐ Both breast and formula ☐ Bottle with breast milk ☐ Bottle with formula

HOW LONG?_____ NAME OF FORMULA _____

ATTACHMENT

☐ Easy
☐ Difficult (AS occip)
☐ Gagging/Coughing/Dribbling (brainstem CN)
☐ Fussy
☐ Arcing backwards (AS occip/TMJ)
☐ Pulling off and shaking (C1/2)
☐ Favours one side (Occip/upper Cx)

TIME TAKEN PER FEED (normal 10-20min) _____ TIME BETWEEN FEEDS _____

REFLUX, PROJECTILE VOMITING (MPA) OR REPETITIVE VOMITING (occ condyle)

HOW OFTEN? _____ DURING, AFTER OR BETWEEN FEEDS? _____

DOES YOUR BABY COUGH OR CHOKE DURING FEEDING (jugular for comp)? Y or N

NUMBER OF WET NAPPIES PER DAY _____ ☐ Smelly urine (UTI)

NUMBER OF BOWEL MOVEMENTS PER DAY _____

☐ Straining ☐ Hard stools ☐ Diarrhoea ☐ Bloating of tummy (lactose intol, coeliac)
☐ Lot of bowel gas (MPA, coeliac) ☐ Explosive diarrhoea (lactose intolerant)

DOES YOUR BABY CRY OR IS IRRITABLE DURING NAPPY CHANGE (Sx sub)? Y or N

AGE OF INTRODUCTION OF SOLIDS _____ TYPE OF SOLIDS_____

SLEEP PATTERNS

DAY: LENGTH _____ EASLY DISTURBED? Y or N IS YOUR CHILD RESTLESS? Y or N

NIGHT: LENGTH _____ HOW OFTEN DOES YOUR BABY WAKE? _____

DOES YOUR BABY SETTLE WELL? Y or N DOES YOUR BABY WAKE DURING THE NIGHT SCREAMING (occ cond)? Y or N

BABYS PREFERED SLEEP POSITION & PREFERED HEAD POSTSION ESPECIALLY IN THE CAR? _____

HEALTH HISTORY

HAS YOUR CHILD HAD A FEVER? Y or N HAVE THEY EVER BEEN HOSPITILIZED Y or N

DOES YOUR CHILD EVER BANG THEIR HEAD REPEATEDLY ON A BED OR A WALL? _____

IS YOUR CHILD VACCINATED? Y or N DOES YOUR CHILD HAVE ASTHMA? Y or N

HAS YOUR CHILD HAD EAR INFECTIONS? Y or N IF YES, WHEN DID THEY START?_____

ARE THEY MORE COMMON ON THE RIGHT OR THE LEFT EAR? LEFT or RIGHT

HAS YOUR CHILD HAS ANTIBIOTICS? _____ ANY VITAMINS?_____

DEVELOPMENTAL HISTORY

AT WHAT AGE DID YOUR CHILD START TO HOLD THEIR HEAD UP? _____ SIT UP? _____ CRAWL?_____

ROLL?_____ WALK?_____ DID THEY BOTTOM SHUFFLE OR COMMANDO CRAWL? Y or N

DO YOU HAVE ANY OTHER CONCERNS ABOUT YOUR CHILDS HEALTH OR DEVELOPMENT? _____

DOES YOUR BABY FREQUENTLY ARCH THEIR HEAD OR NECK BACKWARDS? Y or N

DOES YOUR CHILD OFTEN TRIP AND FALL? Y or N, if yes is there a particular side the fall to? _____

INFORMED CONSENT

Please read the following carefully

After completing your initial consultation with the Chiropractor –

1. I acknowledge that I have discussed with the Chiropractor the rare risks associated with the proposed care of my child which include, although are not limited to, muscle or joint soreness or strains, nausea, dizziness, fractures, disc injuries, strokes (or like episodes) and an exacerbation and /or aggravation of the child's underlying condition.
2. I have had the opportunity to discuss the proposed care of my child with the Chiropractor. I acknowledge that I have had the opportunity to ask questions about the nature, extent and purpose of the proposed care for my child and have been given sufficient time to make a decision giving consent for the care to proceed.
3. I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.
4. I do not expect the practitioner to be able to anticipate all the potential risks and complications associated with the proposed care.
5. I hereby acknowledge my consent to the performance of the proposed Chiropractic care of my child in this centre. I understand I can withdraw my consent at any time.

_____ _____ _____

Parent's Signature Chiropractors Signature Date

PRACTIONER SECTION

INFANT (0-1yr) PHYSICAL EXAMINATION

Vascular

□ Capillary feet refill

□ Femoral Pulses

Orthopaedic Tests - Hips

□Allis'

□ Barlow

□ Thomas

□ Ortolani

Neurology

□ Pull to sitting

□ Hypotonic (floppy)

□ Hypertonic (nervous, sleepless, crying, tense baby)

□ Moro (0-3mnths)

□ Palmer grasp (0-5 mnths)

□ Plantar grasp (0-10 mnths)

□ Rooting reflex (awake 0-4 mnths, asleep 0-7 mnths)

□ Sucking reflex (too strong – comp of maxilla, weak – occ cond comp)

□ Galants reflex (0-2 mnths)

□ Tonic Neck Reflex (2-6 mnths)

□Vertical Suspension (0-4 mnths)

□ Placing reflex (0-6 wks)

□ Walking reflex (0-6 wks)

□ Perez Reflex (0-3 mnths)

□ Landau Reflex (3-24 mnths)

□ Parachute Reflex (6-9 mnths+)

□ Neck Righting Reflex (4-6 mnths to 24 mnths)

MSRs

Jaw jerk		
C5	L	R
C6	L	R
C7	L	R

SHR	L	R
L4	L	R
S1	L	R

Cranial Nerves

□ I (Smell)

□ II (light, vision)

□ III, IV, VI (gaze)

□ V (bite, sensation)

□ V, VI (corneal reflex)

□ VII (facial expression)

□ VIII (Weber, Rinne)

□ XI, X (ahhh)

□ XI (trap/SCM)

□ XII (tongue)

Sublaxation assessment

Cervical
Shoulder
Elbow
Wrist
Lumbar
Hips
Sacrum
Coccyx

Knees
Ankles
ICV
VH
HH

CASE HISTORY

PRESENTING SYMPTOMS AND DURATION

(Possible causes, medical opinions and treatment, pre-history)

Exacerbated by: _____

Relieved by: _____

OTHER PRESENTING SYMPTOMS AND TREATMENT INCLUDING MEDICATIONS

BOWEL OR BLADDER DISTURBANCE, NAUSEA, DIZZINESS, VOMITING?

OTHER PREVIOUS ILLNESS? ALLERGIES

SURGERY / HOSPITAL

ACCIDENTS AND INJURY

FAMILY AND HEREDITIES

NERVOUS DISPOSITION

PHYSICAL ACTIVITIES

MENSTRUAL CYCLE BEGAN Reg:

CYCLE REACTIONS

CONTRACEPTION

SLEEP BEHAVIOUR

NORMAL	Pattern	PRESENT	Pattern
	Position		Position
	Pillows		Pillows

DATE	TREATMENT DETAILS	NEXT VISIT