Lucks Yard Clinic Paediatric form age 0-2

Child's Name: ……..…Date of Birth:……..……

Mother's Name: ……..……Occupation:……

Father's Name: ……..……Occupation:……..

Address: ……..……..……

……..……..…… Post Code……..…

Telephone (Home): ……..…. Telephone (Work): ……..……

Telephone (Mobile): …….. E-Mail Address:……..……

G. P. Name & Address: ……..……..……..…

Health Visitor: ……Do you have any health Insurance?.....

Names & ages of siblings……..

How did you hear about Chiropractic / this clinic?: ……

Present Complaint: ……

Have you consulted anyone else?: ……

Has your baby had any medical treatment / scans / x-rays / surgery?: ……

Are you or your baby on any medication?.....

Was your baby born with any congenital disorder?: ……

Is there any family history of illness?:……..

Has your baby had the following vaccinations?.....1st dose *5-in-1*:.... DTaP/IPV/Hib (2 mo) ☐

2nd dose *5 in1*....Meningitis (3 mo)…☐ 3rd dose 5-in-1…Pneum/Mening (4 mo)…… ☐

Menin/ Hib B/ MMR/ Pneumo (12 mo) ☐ Any reactions?:.....

Has your baby had any childhood illnesses?..... Any known allergies?: ……

Are there any feeding difficulties?: ……

Is/was the baby on Bottle ☐ Breast ☐ Both ☐

When was your baby weaned (if applicable)……Easy to wind?: ……

Any reflux/vomiting?..... a little ☐ a lot ☐ projectile ☐

Sleep well?:..... Use a dummy?: ……

Constant crying?: ……..... Regular bowel movements?: ……

How many wet nappies a day?.....

Lucks Yard Clinic Paediatric form age 0-2

PRENATAL / BIRTH

Any maternal illness or drugs during pregnancy?: ……

Number of previous pregnancies:…….... Number of ultrasound scans?: …….

Duration of Birth: (from onset of labour)…… 2nd stage……

Length at birth…….. Weight at birth……

Head circumference…… AGPAR Score:……

Was the Birth:
(Please circle any of the following that apply)

Premature	Due date	Overdue by_____days/weeks
Induced	Forceps	Ventouse
Breech	Face or forehead presentation	
If Caesarean	Planned	Emergency
Did the Baby Have:	Bruising	Jaundice Special Care_____

Milestones:
Tick if achieved / cross if not achieved yet

6 weeks	smiling…….	3 months	Head steady……..
7 months	sits unaided…….	9 months	stands unsupported…….
11 months	crawling…….	12 months	2 or 3 recognisable words……....
14 months	walks unaided…….	16 months	holds and drinks from a cup……..

CHILD CONSENT

I hereby give my consent for my child …….. to be examined by the Chiropractor using chiropractic methods as seen fit.

Parent / Guardian ……..…….....
(Signature)

Signed ……..…….. Date…….
(Print Name)

Lucks Yard Clinic Paediatric form age 0-2

Date	Patient Name	Patient Number
1. MOTHERS ANTENATAL HISTORY Pregnancy Prev pregnancies Illnesses Infection Vomiting Pre-eclampsia Anaemia Back pain Diet **2.PERINATAL HISTORY** Place of birth Duration of preg Duration of labour Ease of birth Intervention **3. HISTORY OF CONDITION** **4. ONSET** **5.AGGRAVATING FACTORS** **6. RELIEVING FACTORS** **7. ASSOCIATED SYMPTOMS** **8. CHILDS'S HEALTH** **BREAST** HOW MUCH? HOW OFTEN? DIFFICULTY? SUCK SWALLOW BREATHING 1 2 3 4 5		**BOTTLE** BRAND? CHANGE? HOW MUCH? HOW OFTEN?) **SOLIDS/WEANING** WHEN? LIKES / DISLIKES **REGURGITATION** **ALLERGIES** **INTOLERANCES** **FLATUS** **COLICKY**? **BOWELS** FREQ? VOLUME? COLOUR? TEXTURE? ODOUR? MUCOUS? DIFFICULTY? **BLADDER** NUMBER WET NAPPIES? **SLEEP** PATTERN? DURATION? POSITION? **CRYING** PATTERN? DURATION? FREQUENCY? PITCH? EASILY UPSET? **9. OTHER RELEVANT INFORMATION** Temperature control Alertness Responsiveness Spontaneous movements ENT