Luck's Yard Chiropractic Clinic Age 2-10 Date File No

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

Mother's Name: ……Father's Name: ……..……..

Address: ……..……..……..……..……...

……..……..…….. Post Code…….

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

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

G. P. Name & Address……..……..……..

Do you have any health insurance? Yes No Which company.....

How did you hear about Chiropractic / this clinic? GP Health Visitor Friend/Family

Internet search Our website Advert Other: …….

Present Complaint:

……..……..…

Have you consulted anyone else?: ……..……..……...

Is your child on any medication? …….....

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

Was your child born with any congenital disorder?: ……..……

Any road traffic accidents or other accidents?.....

Has your child had any vaccinations?.....Any reactions?:.....

Has your child had any childhood illnesses?.....

Any known allergies?: ……

Does your child have a good diet? …….

Regular bowel movements?: ……..……

Does your child sleep well? Yes No

Is your child dry by day Yes No

Dry by night? Yes No .

No: of siblings.....

Any other information you think might be relevant? …….

……

……

……

……

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PRENATAL / BIRTH

Any maternal illness or drugs during pregnancy?: ……

Were there any complications during delivery?.....

How was your child fed? Breast Bottle Both When did they start solids?.....

Milestones:
Tick if achieved / cross if not achieved

7 months - sits unaided…… 9 months - stands unsupported……..

Did your child bum-shuffle? Yes No

11 months – crawling …….. 14 months - walks unaided……..

2 years – says short sentences……. 3 years – self dressing……..

FAMILY MEDICAL HISTORY
(parents/siblings)

- Allergies	Yes	No
- Reflux/IBS	Yes	No
- Asthma	Yes	No
- Headaches/Migraines	Yes	No
- Skin disorders	Yes	No
- Delayed Development	Yes	No

CHILD CONSENT

I hereby give my consent to physical examination for my child …….. by the Chiropractor.

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

(Print Name)……..

Under the Data Protection (1998) Act, we are required to retain information for the purpose of consultation for treatment, recording subsequent treatment, and for the use of third party medical practitioners only, at the request of the patient, in writing.
Upon completion of the Patient Details Form, Data Protection and Consent forms, all paper files and information therein may be electronically scanned and stored on computer file for as long as the patient remains a patient of the Clinic, and upon completion of treatment for a period of no less than 7 years thereafter.
All information are held in files only accessible by the staff of the Clinic, who are directly involved in the data entry and processing of patient records. I, the undersigned (Parent/Guardian), acknowledge that I have read the Data Protection Policy (above) and do hereby give consent to the Chiropractor to maintain records for the purpose outlined within the policy

Parent / Guardian ……..... Date……

I have read the information sheet and leaflets and been given a Report of Findings regarding my child's condition.
I have had the opportunity to ask questions and been advised of all treatment options available. I have been advised of possible side effects associated with treatment. I consent to chiropractic treatment for my child as outlined to me.

Signed…….. Date……

Luck's Yard Chiropractic Clinic Age 2-10 Date File No

Date	Patient Name	Patient Number
1. **HISTORY OF CONDITION** **2. ONSET** **3.AGGRAVATING FACTORS** **4. RELIEVING FACTORS** **5. ASSOCIATED SYMPTOMS** **6. MOTHERS ANTENATAL HISTORY** **7. NEONATAL HISTORY** **8. FAMILY HISTORY** **9. CHILDS'S HEALTH** NOURISHMENT HYDRATION MUSCLE TONE JOINT MOBILITY	 	**9. CHILDS'S HEALTH** **ALLERGIES OR INTOLERANCES** **FEEDING/DIET** **FUSSY EATER** **FLATUS** **BOWEL HABITS** **ANAL FISSURES** **BLADDER** **SLEEP** **CRYING** **PHYSICAL DEVELOPMENT** **GROWTH CHARTS** **CRAWLING/GAIT** **PRE-SCHOOL** **HOME** **RECREATION** **ACTIVITY LEVELS** **10. OTHER RELEVANT INFORMATION** Headaches TATT Hyperactivity Difficulty sitting still or catching ball Sensory Integration Dysfunction Emotional Anxiety Dyslexia/Dyspraxia

Luck's Yard Chiropractic Clinic Age 2-10 Date File No

EXAMINATION

General observation

Eyes
Skin
Rash
Birth marks
Colour
Hyper/hypotonicity
Tremor
Hand dominance L R

Vital signs

Temperature..……..^{o}C
Heart rate……..……..pm
Respiratory rate..……...pm
Height…….…….....cm
Weight……....Kg

Urinalysis

Medical Examination

HEENT Head Ears Eyes Nose Throat	
Neck Cervical ROM Lymphadenopathy	
Chest Inspection Palpation Auscultation Chest expansion	
Abdominal Diaphragm Masses Tenderness Bowel sounds Distention/herniae AA pulse	
Extremities Cyanosis Clubbing Oedema Nail changes Peripheral pulses	

PGALs Check

Gait – normal heel toe
'Touch the Sky'
'Touch your toes'
'Hands out'
'Fists/turn'
'Fingers touch'
'Jaw ROM'

Primitive Reflexes still present?

Galant/Perez	**Yes**	**No**
SLR	**Yes**	**No**
ATNR	**Yes**	**No**
STNR	**Yes**	**No**
Moro	**Yes**	**No**

Red/Yellow Flags?

Unexplained bruises/marks?

Inconsistent Findings?

Age-appropriate Speech and language

Alert	Yes	No
Co-operative	Yes	No
Speech clear and meaningful	Yes	No
Speech volume	Satisfactory	Unsatisfactory
Comprehension of language	Appropriate	Inadequate
Social interaction	Appropriate	Inadequate

Muscle testing

L Arm R Arm

L Leg R Leg

R Leg L Arm
R Arm L Leg

Across midline

Arms L/ R
Legs L/ R
L Arm and R Leg

R Arm and L Leg

Visual Tracking L……Midline…….....R

Convergence L……..Midline……..…R

Visual Movement **x……..x……x**

L **x……..x……..……x** **R**

x……x……x

NOTES:

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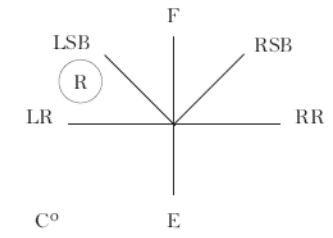
CRANIAL NERVES

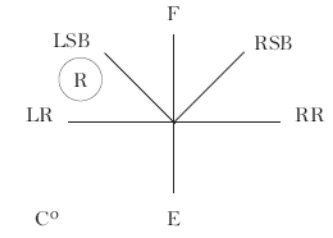
CN	Action	R	L
II	Turns head to object in visual field? Fields - full to confrontation - pupil diameter - pupil symmetry - reactive to light (direct and consensual) - accommodation - convergence - visual tracking Fundus		
III / IV / VI	Conjugate eye Extra-ocular movements full Nystagmus/ Ptosis		
V	Motor – tone of mastication muscles		
VII	Facial expression – symmetrical Blink Unexplained lacrimation		
VIII	Eyes look toward sound		
IX /X	Gag reflex Palate elevation Speech and swallow observed		
XI	SCM – symmetrical head rotation?		
XII	Tongue - Protrusion to midline? - Full strength - Fasciculation?		

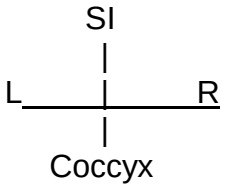
Motor - Upper Limb	**R**	**L**
Deltoid		
Triceps		
Biceps		
Wrist Ext		
Wrist Flex		
Grasp		

Motor - Lower Limb	**R**	**L**
Ileo-psoas		
Quads		
Hamst		
TFL		
Gast/Sol		
Tib And		

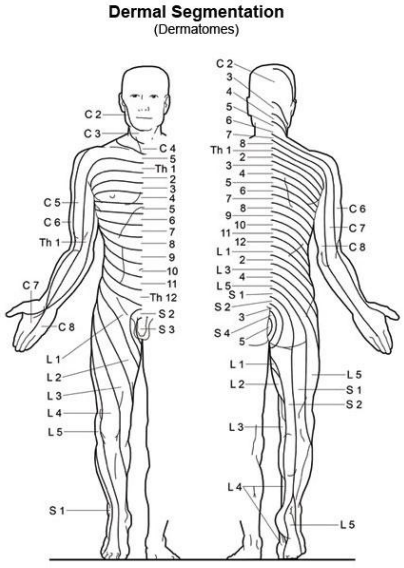
	Occ C1	
	C1 C2	
	C2 C3	
	C3 C4	
	C4 C5	
	C5 C6	
	C6 C7	
	C7 T1	
	T1 T2	
	T2 T3	
	T3 T4	
	T4 T5	
	T5 T6	
	T6 T7	
	T7 T8	
	T8 T9	
	T9 T10	
	T10 T11	
	T11 T12	
	T12 L1	
	L1 L2	
	L2 L3	
	L3 L4	
	L4 L5	
	L5 S1	







Gait
SLR
Short leg
Faber
Gaenslen's
Cx



Reflexes:	L	R
Biceps		
Triceps		
Radial		
Abdominal		
Knee		
Achilles		
Plantar		

Alert	yes	no
Cooperative	yes	no
Visual Contact	yes	no
Speech	yes	no
Comprehension	yes	no
Social Interaction	yes	no

Scoliosis
Balance

Luck's Yard Chiropractic Clinic Age 2-10 Date File No

CRANIAL Examination

Frontal
Sphenoid
Parietal
Temporal
Occiput
Facial Vault
Maxilla
Palate
Mandible
Zygoma
Sutures
Intra-oral
Nasal

CASE SUMMARY	PATIENT NAME: ……. D.O.B ……..
1. Presenting Complaint 2. Relevant Assessment Findings 3. Diagnosis / Clinical Impression 4. Differential Diagnosis 5. Plan of Management 6. Objectives for Care 7. Prognosis / Prognosis Factors 8. Report of Findings 9. Review Date	

X-RAY / SPECIAL IMAGING REPORT

X-Rays Evaluated (inc views, dates and institution)

Radiological Findings

Clinical Impression

Further Studies

Referral

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Date	Patient Name	Patient No:

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Date	Patient Name	Patient No: