Confidential Paediatric History Information

This form can either be completed online or you can print a hard copy and return it by post or email.

Please note: for the best experience, it is recommended to download this interactive form to your device and use Adobe Acrobat Reader to view and fill in. Acrobat Reader is a free pdf viewer and is available to download for Mac, PC, iOS, Android and Windows Phone here: https://www.adobe.com/uk/acrobat/pdf-reader.html

Child's Full Name: ______________________

Parent/Guardian's Full Name: ______________________

Date of birth: ____________ Age: ____________ Sex: M F

Weight: ____________ Height: ____________

Home Phone Number: ____________ Parent/Guardian's Mobile: ____________

Parent/Guardian's Email Address: ______________________

Home Address: ______________________

City/Town: ____________ County: ____________ Postcode: ____________

Reason for visit: Spinal/Posture Health Check Other ____________

Name of Paediatrician/GP: ____________ Date of last visit: ____________

Reason for visit: ______________________

Any other health concerns for your child: ______________________

Number of antibiotic doses your child has taken: ______ Most recent dose: ______ Total in lifetime: ______

Prescription medications: ______________________

Over the counter medications: ______________________

Has your child received any vaccinations? Yes No Were there any reactions to the vaccine received? Yes No

Of the conditions listed below, does your child experience any **C**urrently or has he/she in the **P**ast?
Please tick **P** and/or **C** as appropriate.

Condition			Condition			Condition		
Ear infections	P	C	Scoliosis	P	C	Seizures	P	C
Chronic colds	P	C	Asthma	P	C	Allergies	P	C
ADHD	P	C	Recurrent fevers	P	C	Digestive problems	P	C
Constipation	P	C	Diarrhoea	P	C	Growing pains	P	C
Temper tantrums	P	C	Car accident	P	C	Lack of energy	P	C
Fractures	P	C	Colic	P	C	Headaches	P	C
Bed wetting	P	C	Other: ____________					

Prenatal History

Complications during pregnancy: ______________________________

Was there any stress (physical, chemical, emotional) during the pregnancy? ______________________________

Ultrasound scans: Yes No How many? ______________________________

Medications: ______________________________

Cigarette/Alcohol use during pregnancy: Yes No

Birth History

Location of birth: Hospital Home Birthing Centre

Antibiotics during delivery (or in the three months prior to delivery): ______________________________

Medications during delivery: ______________________________

Length of labour: ______________________________ Length of delivery: ______________________________

Birth intervention: None Forceps/vonteuse Caesarean section (emergency/planned)

Complications during delivery: ______________________________

Genetic disorders/Disabilities: ______________________________

Medications during delivery: ______________________________

Birth weight: ______________ Birth length: ______________ Apgar Score: ______________

Full term: ______________ Premature: ______________

Feeding History

Breastfed: Yes No For how long? ______________ Formula fed: Yes No For how long? ______________

Solids introduced at ______________ months Cow's milk introduced at: ______________ months

Food allergies or intolerances: ______________________________

Developmental History

The following events are very important in your child's spinal health and general wellbeing. During these times your child's spine and nervous system are going through rapid changes and should be routinely checked to help optimise neural and postural development.

At what age was your child able to: (put your best estimate)

Respond to sound ______________ Respond to visual stimulus ______________

Hold head up ______________ Sit up ______________

Crosscrawl ______________ Stand alone ______________

Walk alone ______________

Did your child use a babywalker/saucer, Jolly Jumper: Yes No For how long? ______________

Childhood Diseases

Chickenpox age: ____________________ Measles age: ____________________ Meningitis age: ______________________

Mumps age: ________________ Whooping cough age: ____________________________ Other: ______________________

Regarding your child today

Is your child involved in any high impact/contact type sport? Yes No Please list:

____

Is your child accident-prone/clumsy? Yes No

Has your child had any falls down steps/out of pram? Yes No

Has your child ever fallen from heights over 2 feet or off a horse? Yes No

Has your child ever been in a car accident? Yes No

Has your child ever been hospitalised? Yes No

Is your child taking any medication? Yes No

Does your child have any learning disabilities Yes No

Has your child had a scoliosis examination? Yes No

Does your child have any sleeping difficulties? Yes No

Does your child have poor posture? Yes No

Does your child show signs of hyperactivity/difficulty focusing? Yes No

Is your child nervous/emotional? Yes No

Please elaborate on the answers you have responded Yes to:

Your child's health often affects your own health. If you could improve any aspect of your child's health or behaviour, what would it be?

Consent to Examination for a minor (under 16 years of age)
I hereby grant permission for this office and its chiropractors to perform a physical examination.

Please tick to indicate your consent and opt in

I understand my child's records will be held on file for eight years after the last appointment with Vibrant World Chiropractic or until my child reaches 25 years old, whichever is the longer time and this is a legal requirement.

Yes, please remind me of upcoming appointments via email or text.

I would like to be told about upcoming events at and news of Vibrant World Chiropractic via email and occasionally by post.

Thank you for choosing our office. We are excited at the possibility of assisting you and your family on your journey towards staying well and feeling alive!

To be completed in the office, following the report of findings.

Consent to treatment: I consent to treatment for my child as explained by the chiropractor.

Name of Parent / Guardian (BLOCK CAPITALS)

Parent / Guardian signed

Date

Important! After completing the form: **1. Save your form** and then: **2. Click the 'SUBMIT FORM' button** below.

If you are filling in by hand, please scan your completed form and email to info@vibrantworld.co.uk. Alternatively, return by post to Vibrant World Chiropractic, at Castle Street Clinic, 36-37 Castle Street, Guildford, Surrey, GU1 3UQ

You can also use the **'PRINT FORM' button** to print a copy for your own records, if you wish.

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