Hereford Osteopathic Centre

Clinic Director: Nicholas Handoll, DO, MSCC

Holland House, 70 Belmont Road, Hereford, HR2 7JW
Telephone: 01432 - 356655

Before you bring your child to see us it would be most helpful if you would please complete the following questionnaire and return it to us before the appointment. This will enable us to make the best use of the time available, as well as enabling us to avoid subjects that are best not discussed in front of your child. (Please mark your envelope QUESTIONNAIRE).

Please try to answer each question, even if the answer is "No" or "I don't know".
Thank you for your help.

PLEASE FILL IN ALL 5 PAGES IN EVERY CASE ***Thank you***

DATE……………………………………………………………….:

CHILD'S NAME ……..……………………………………………. MALE / FEMALE

NAME OF PARENT OR GUARDIAN: ………………………………………………………...

ADDRESS: ……………………………………………………………………………………….

………………………………………………………………………………………………………..

Tel. No. (Home): ……………………………………………………………………….

(Work): ……………………………………………………………………….

(Mobile) ……………………………………………………………………….

Your GP's name ....………………………………………...

Address ....

How did you hear about this practice?

....……..

MEDICAL INSURANCE.

If you have health insurance please write name of company here ……………………………

To find out if you are covered for osteopathy please contact your insurance company.
Please ask the receptionist for a receipt so that you may reclaim the fee.

Your child/baby's Date of Birth: ……………………………. Birth Weight: …………………

Brothers and sisters (dates of birth & birth weights, any health problems).

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

PROBLEMS Reasons why you are bringing your child/baby.

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

About the baby/child's mother:

How did you feel during your **PREGNANCY**? …………………………………………………

……………………………………………………………………………………………………

What was your age during this pregnancy?

……………………………………………………………………………………………………

Did you experience any problems?

……………………………………………………………………………………………………

Did you take any medication?…………………………………………………………………

Did you have any of the following tests: ultrasound scan, nuchal scan,
x-ray, amniocentesis, chorionic villus sampling, alpha fetal protein ? …………………………

……………………………………………………………………………………………………

Did the baby move about much in the womb?……………………………………………………

Can you recall when the baby's head was said to be engaged?…………………………………

DELIVERY (a copy of your hospital discharge summary would be helpful)

Was your baby born on the due date, if not how many days early or late? ……………………

Did you deliver in hospital or at home? …………………………………………………………

Was the delivery as you had hoped? ………………………………………………………………

Did your labour begin of its own accord or were you induced? ……………………………………

Did your waters break on their own without the midwife's help? ………………………………

What was the presentation? ……………………………………………………………………

How long was the **first stage** (the dilatation stage)? ……………………………………………

Did you move about much during this stage? …………………………………………………..…

How long was the **second stage** (the pushing stage)? ………………………………………...

What position were you in when the baby delivered? …………………………………………..

Were there any problems with the **third stage** (delivery of the afterbirth)? ……………..….

…………………………………………………………………………………………………

Did you have any pain relief? …………………………………………………………………...

Was the baby stuck at any stage? ……………………………………………………………..

Were any instruments used, e.g. forceps, vacuum pump? …………………………………...

…………………………………………………………...………………………………………

Any problems during the delivery?

…………………………………...………………………………………………………………

AFTER DELIVERY.

APGAR SCORE, if known. 1 minute .... 5 minutes .....…...

How long was it before the baby was given to you? ……………………………………………

Within the first 30 minutes did the baby cry? …………………………………………………….

Within the first 30 minutes did the baby suck? …………………………………………………..

Was there anything particular you noticed about the baby's head?

…………………………………………………………………………………………………

Did the head shape change a lot during the first 24 hours. …………………………………….

During the first week did the baby settle between feeds? ……………………………………...

FEEDING. Breast or bottle? ……………………………………………………………………….

If bottle what type of formula? ……………………………………………………………………..

Any difficulties? ……………………………………………………………………………………..

Weight gain? ………………………………………………………………………………………..

When were solid foods introduced? ………………………………………………………………

Has your child had any problems with their bowels? ……………………………………………

SLEEPING (how quickly was a routine established)? …………………………………………..

VACCINATIONS (which ones has your child had and were there any reactions)?

Diphtheria Polio Tetanus (DPT) …………………………………………..

Hib (Meningitis) ………………………………………………………………………………..

Pertussis (Whooping Cough) ……………………………………………………………...

MMR (Measles, Mumps and Rubella) ……………………………………………………….

BCG (Tuberculosis) ……………………………………………………………………………...

ILLNESSES (including infections and any medication given).

……

……

……

……

MEDICATION What drugs or medicines is your child taking now (include skin applications and creams)?

……

……

……

……

Any medications in the past?

……

……

……

ACCIDENTS

……

……

……

HOSPITAL ADMISSIONS (casualty, tests, treatments, operations).

……

……

……

……

DENTAL HISTORY (any problems, treatment, or orthodontics)…………………………………..

………

OTHER TREATMENTS (such as homoeopathy, occupational therapy, physiotherapy etc).

………

………

………

SCHOOL OR NURSERY (please give the school name; is there anything special about it?)

………

………

Roughly what age did your child:

Hold their head up? ……………..……………… Sit without support? ………………………..

Crawl?…………………………………………….. Talk? ………………………………………...

Walk?……………………………………………… Potty train? ………………………………….

MOVEMENTS & FAVOURITE POSITIONS (have you noticed any asymmetries or difficulties)?

………

………

………

FAMILY GENERAL HEALTH (parents, grandparents, aunts and uncles).

………

………

………

Is there a family history of any of the following:

Asthma. ………………………………………….. Eczema. …………………………………….

Hayfever………………………………………….. Diabetes. ……………………………………

Do you or does anyone in your household smoke? …………………………………………….

How many cigarettes per day for each smoker? ………………………………………………...

Are there any pets in the house? …………………………………………………………………

………

Please continue on the back if there is anything else that you would like to mention.
Thank you.