

WELCOME TO HEALTHSPACE AND THANK YOU FOR CHOOSING US!

CHILD'S NAME

D.O.B.

ADDRESS

GUARDIAN 1. NAME:

RELATIONSHIP

GUARDIAN 2. NAME:

RELATIONSHIP

Guardian Phone: HOME

MOBILE

WORK

Guardian Email Address

NAMES & AGES OF SIBLINGS

PRIVATE HEALTH FUND

GENERAL PRACTITIONER

GP ADDRESS & PHONE NUMBER

Who can we thank for referring you to HealthSpace?

GENERAL HEALTH HISTORY—If the mother or child has had any of the following, please circle Yes or No.

PRENATAL (CONCEPTION TO BIRTH)

While pregnant with your child, did the child's mother:

Have a sedentary lifestyle	Yes	No
Smoke or drink alcohol	Yes	No
Have a poor diet	Yes	No
Have any falls or injuries	Yes	No
Suffer from high blood pressure	Yes	No
Suffer any other illness	Yes	No
Take any prescribed medications	Yes	No
Have Proteinuria	Yes	No
Have X-rays/ultrasound	Yes	No
Duration of pregnancy in weeks		
Age of mother at time of birth		
Any previous miscarriages/stillbirths?		

PERINATAL (BIRTH)

During the birth did any of the following occur?

Premature delivery	Yes	No
Long or difficult delivery	Yes	No
Forceps or Vacuum extraction	Yes	No
Caesarean section	Yes	No
Breach or other unusual presentations	Yes	No
Use of drugs during labour	Yes	No
Labour induced	Yes	No
Length of time in labour—Stage 1:..... Stage 2:		
APGAR score at 1min: 5 mins		
Weight at birth Length at birth		
Head circumference		

NEONATAL

Immediately after the birth/during infancy, did any of the following occur?

Need for child to be respirated	Yes	No
Need for child to be kept in a humidicrib	Yes	No
Administered any medications	Yes	No
Other significant accidents	Yes	No
Difficulty feeding / latching / sucking	Yes	No
Head banging or rocking	Yes	No
Recurrent childhood sicknesses	Yes	No
Surgery	Yes	No
Failure to grow / gain weight	Yes	No
Show any unusual movements	Yes	No
Had disrupted sleep patterns	Yes	No
Had speech or language difficulties	Yes	No

☐ Breast-fed ☐ Bottle-fed ☐ Formula Type

Any of the following childhood illness:

☐ Measles ☐ Rubella ☐ Mumps ☐ Chicken Pox

Any allergies or sensitivities

OTHER

Please circle any other relevant conditions below:

Teeth	Eyes	Hearing	Cough/colds
Headache	Backache	Gas	Bloating
Constipation	Diarrhoea	Hard stools	Loose Stools
Poor circulation	Hot/cold hands or feet	Reflux	Palpitations
Difficulty urinating	Frequent urinating	Skin rashes/conditions	
Nappy rash	Flaking scalp		

VACCINES & IMMUNISATIONS

Has your child received all the recommended immunisations? ☐ Yes ☐ No ☐ Some

Vaccine names

Age Given: