

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:

MEDICAL HISTORY—Has your child ever experienced any of the following?

More than 2 ear infections	Yes	No
Hearing Difficulties	Yes	No
Visual Difficulties	Yes	No
Movement Problems (special shoes/split/braces)	Yes	No
Failure to thrive	Yes	No
Poisoning / overdose	Yes	No
Fainting / unconscious spells	Yes	No
Convulsions / seizures / epilepsy	Yes	No
Bed wetting beyond 5 years old	Yes	No
Sleeping Difficulties	Yes	No
Poor growth or excessive weight gain	Yes	No
Reactions to immunisations	Yes	No
Headaches	Yes	No
Any night pain	Yes	No
Production of unusual odours	Yes	No
Difficulty swallowing	Yes	No
Loss of previously obtained skills (speech / motor)	Yes	No
Toe walking	Yes	No
Run / walk more awkwardly than kids their age	Yes	No
Unusual movements / tics	Yes	No

Has your child ever been diagnosed with a developmental disorder?

YES / NO

Has your child ever received any special education or counseling?

YES / NO

Have you consulted other professionals regarding your child before?

YES / NO

Is your child currently on any medications or taken any in the past?

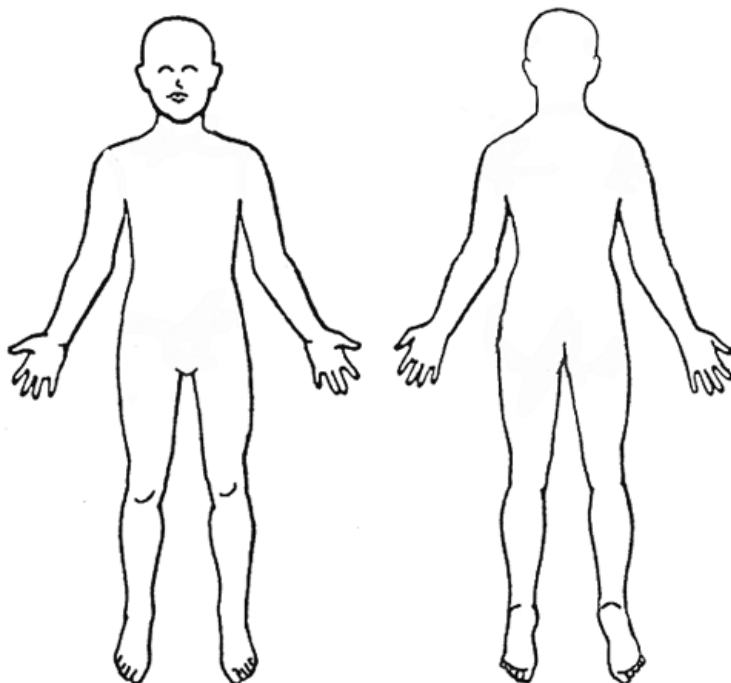
YES / NO If yes, please list what and why:

SOCIAL SKILLS

Does your child:

Tend to be the boss or the follower	Yes	No	Sometimes	Have temper tantrums or lose their temper easily	Yes	No	Sometimes
Avoid affection	Yes	No	Sometimes	Appear to have their feelings hurt easily	Yes	No	Sometimes
Play and take turns with other kids readily	Yes	No	Sometimes	Avoid eye contact with people	Yes	No	Sometimes
Appear to be in a world of its own/daydream frequently	Yes	No	Sometimes	Mood change easily	Yes	No	Sometimes
Exhibit repetitive movements when stressed or excited	Yes	No	Sometimes	Get frustrated easily	Yes	No	Sometimes
Appear frightened / anxious in new situations	Yes	No	Sometimes	Get easily distracted	Yes	No	Sometimes
Have <u>verbal/physical</u> fights with adults/children/parents	Yes	No	Sometimes	Frequently stand aside of a group of kids their age	Yes	No	Sometimes
How long can you child sit while watching a fascinating activity or be read to?							

Please mark on the diagram below where your child is experiencing or showing signs of discomfort:



DEVELOPMENT

< 6mths / 6-12 mths / 18-24 mths / 24-36 mths / 36-48 mths / >48 mths

Approximately how old was your child when they first::

Had more than 2 ear infections

Crawled.....

Stood unsupported.....

Walked with assistance.....

Walked without assistance.....

Showed hand preference

Toilet trained (bowel).....

Trained (bladder).....

Began to use words

Began to talk in sentences

Began to vocalize (babble).....

Which hand does your child prefer