Osteocare Infant Questionnaire

Name ……DOB / / Age …….. Sex M / F .....
Mother's name …….Father's name .....
Siblings name/s .....
Referred by .....
Address …… P/Code .....
Telephone: Home……Mobile……Email .....

How did you hear about Osteocare? (Please Circle)

Internet Yellow Pages Drove Past Referral (eg. Friend, family, health professional)

Other (please specify): ……. If Referral, who? .....

AREA OF CONCERN

What is the nature of your child's reason for this consultation, as you see it?
.....
.....
Has your child been diagnosed with a disease or condition ☐ No ☐ Yes
If yes, what? .....
Who made the diagnosis?
Name ……Profession .....

PERINATAL HISTORY

Where there any complications with the pregnancy? ☐ No ☐ Yes
If yes, please detail:.....
.....
When were ultra-sound examinations performed?
☐ 12wks ☐ 20wks ☐ Other .....
Mother's age at the time of birth: ……. Years Week of birth ____ /40 +___

Where did the birth occur?
☐ Home ☐ Birthing Centre ☐ Hospital ☐ Other .....

Total length of labour: …… Hours ☐ Easy ☐ Difficult
Length of 2nd stage: ……..

Were forceps or vacuum extraction used? ☐ No ☐ Yes
If yes, please detail:.....
Was caesarian section performed? ☐ No ☐ Yes
If yes, was it elective? …… Please detail: .....

What were the APGAR scores at: 1 minute: _____ /10 5 minutes: _____ /10

Where there any complications with mother during labour/delivery? ☐ No ☐ Yes
If yes, please detail:.....
Where there any complications with baby during labour/delivery? ☐ No ☐ Yes
If yes, please detail:.....
Was there a delay with the first breath ☐ No ☐ Yes Please detail .....

How soon after the delivery was the placenta cut?
☐ Immediately ☐ Pulsations had ceased ☐ Other .....
Was the baby's head:
☐ Bruised ☐ Flattened ☐ Other irregular contours (please describe).....

****Please attach a photo of your child's head within the first 12 hours of delivery if possible****

What were the initial measurements?
Birth weight _____g Head circumference _____cm Length _____cm

Was the baby:
☐ Quiet ☐ Contented ☐ Too active ☐ Irritable ☐ Fussy feeder

Please list any problems with the baby in the first six weeks after birth
.....
.....

VACCINATIONS
Has your child been vaccinated? ☐ No ☐ Yes
If no:
☐ Homeopathic ☐ Other .....
Where there any reactions with any vaccinations administered? ☐ No ☐ Yes
If yes, please detail:.....

FEEDING
Is/was your child breastfed? ☐ No ☐ Yes
If yes: For how long? …….
Any complications? ☐ No ☐ Yes (☐Infant and/or ☐ Maternal)
Did you have to exclude any foods from your diet? ☐ No ☐ Yes
If yes, please detail:.....
If your child is/was bottle fed, what formula was used? .....
Does or has your child had any problems with: Reflux ☐ Wind ☐ Other .....

Bowel functions: Frequency ……. Colour .....

SLEEPING
Does your child have any difficulty with sleep? ☐ No ☐ Yes
If yes, please detail:.....
Does your child require:
☐ More sleep ☐ Less sleep ☐ Average/normal amount
Does your child:
☐ Self rock ☐Head bang ☐Thumb suck ☐ Other .....
Does your child have difficulty:
☐ Getting to sleep ☐ Staying asleep ☐ Other .....

MILESTONES
How old (in months) was your child when he/she first began:
Rolling …… Sitting …… Commando Crawl …… Conventional Crawl…….
Walking ……
Does your child move in an abnormal manner? ☐ No ☐ Yes Please detail .....

MEDICAL HISTORY Does your child have problems in the following areas?

Ears, Nose and Throat

Frequent ear infections? ☐ No ☐ Yes Please detail:.....
Difficulty hearing? ☐ No ☐ Yes Please detail:.....
Nose disorder? ☐ No ☐ Yes Please detail:.....
Throat disorder? ☐ No ☐ Yes Please detail:.....
Other .....

Heart and Lungs

Bronchial disorder? ☐ No ☐ Yes Please detail:.....
Chronic cough? ☐ No ☐ Yes Please detail:.....
Heart disorder (including murmurs)? ☐ No ☐ Yes Please detail:.....
Other .....

Gastrointestinal

Does your child experience any of the following?

☐ Diarrhoea ☐ Constipation ☐ Alternating diarrhoea / constipation
☐ Gas ☐ Other.....

Stomach disorder? ☐ No ☐ Yes Please detail:.....
Intestinal disorders? ☐ No ☐ Yes Please detail:.....
Other .....

Genitourinary

Kidney disorder? ☐ No ☐ Yes Please detail:.....
Bladder disorders? ☐ No ☐ Yes Please detail:.....
Frequent urinary infections/disorders? ☐ No ☐ Yes Please detail:.....
Other .....

Skin

Skin disorders? ☐ No ☐ Yes Please detail:.....

Bone

Bone or joint disorder? ☐ No ☐ Yes Please detail:.....
Fractures? ☐ No ☐ Yes Please detail:.....

Other .....

Central nervous system

Head or brain injury? ☐ No ☐ Yes Please detail:.....
Nerve or muscle disorder? ☐ No ☐ Yes Please detail:.....
Other .....

FAMILY HISTORY

Have any of your nearest relatives (i.e. parents, grandparents, siblings, etc.) had a major illness? ☐ No ☐ Yes

If yes, please list:.....
.....
.....

Please read and sign the following as recognition of our clinic policies.

Privacy Policy:

Osteocare only collects information from our patients that is necessary in providing the best possible care and allows us to appropriately and thoroughly diagnose, treat and manage our patients. We aim to ensure that any information we hold is accurate, complete and up to date.

The health information that you provide is treated with the strictest of confidence and will only be disclosed to a third party (eg. health professional, insurance company etc.) with your written consent, unless we are legally obliged to do so.

Osteocare takes appropriate steps to ensure that all the information we hold is protected from loss, misuse, or unauthorised access, disclosure or modification. Our premise is secure, and access to our computer system is limited by user identifiers and passwords. All our staff are subject to strict obligations of confidentiality.

In handling your personal information, Osteocare is committed to complying with the Privacy Act 1988 and the National Privacy Principles (NPP) effective under the Privacy Amendment Act 2001, and operates in accordance with the Ethical Principles of the Australian Osteopathic Association.

I have read the above Privacy Statement, and consent:

Signature: _____ **Date:** **/** **/**
(Parent/Guardian)

Cancellation and 'No Show' Policy:

Thank you for choosing Osteocare to provide your manual therapy needs. Please read the following two policies, then sign your name where indicated.

Cancellation Policy:
If you need to cancel an appointment at Osteocare, please call us ASAP (24 hours notice) so we have the opportunity to offer your appointment to another patient.
If less than 24 hours notice is given I acknowledge that I will be charged a $30 fee.

'No Show' Policy:
If you do not show up for a scheduled appointment, you will be charged a $30 fee.

I understand these terms. I realise that I am financially responsible for charges incurred from cancellations or no shows.

Signature: _____ **Date:** **/** **/**
(Parent/Guardian)