The Sharon Winkler Osteopathic Practice

BSc (Hons) Osteopathy, PG Cert (Small animal rehabilitation therapy), Osteopathy for people and animals

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INFANT AND CHILD EVALUATION FORM

Before you bring your child it would be most helpful if you could fill out the following questionnaire and return it before the appointment. This will enable 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 try to answer each question, even if the answer is "No" or "I don't know".

Thank you for your co-operation.

TODAY'S DATE:

CHILD'S NAME: **MALE** **FEMALE**

NAME OF PARENT OR GUARDIAN:

ADDRESS:

TEL. NO. (Mobile)

(Home)

EMAIL

YOUR GP'S NAME:

GP'S ADDRESS:

MEDICAL INSURANCE (To find out if you are covered for osteopathy, contact your insurance company)

If you have medical insurance, please write the name of the company here:

Please sign here to give your consent for one of our osteopaths to examine and treat your child. Thank you.

SIGNED:

DATE:

All information you share with us will be treated as confidential. For further details on our privacy policy please see: sharonwinkler.co.uk/privacy or contact us at: enquiries@sharonwinkler.co.uk

YOUR CHILD / BABY'S DATE OF BIRTH **BIRTH WEIGHT**

Does your child/baby have any brothers or sisters **YES** **NO**

IF YES, PLEASE NOTE THEIR DATES OF BIRTH, BIRTH WEIGHTS, AND ANY NOTABLE HEALTH PROBLEMS THEY HAVE:

REASON FOR YOUR VISIT: Please briefly explain why you are bringing your child/baby to see us:

Were you advised to bring your child/baby to see an osteopath by another practitioner? (i.e. midwife, health visitor, lactation consultant, tongue tie specialist, GP, etc.) **YES** **NO**

IF SO, THEIR NAME AND CONTACT DETAILS WOULD BE HELPFUL:

About the mother's pregnancy

How did you feel during your pregnancy?

What was your age during this pregnancy?

Did you experience any problems during this pregnancy? **YES** **NO**

IF YES, PLEASE DETAIL:

Did you take any medication during this pregnancy? **YES** **NO**

IF YES, PLEASE DETAIL:

Did you have any of the following tests: (tick all that apply)

ULTRASOUND SCAN **NUCHAL SCAN** **X-RAY** **AMNIOCENTESIS**

CHORIONIC VILLUS SAMPLING **ALPHA FETAL PROTEIN**

Did your baby move about a lot in the womb?

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

Delivery Stage

Was your baby born on the due date: **YES** **NO**

If not, how many days late or early?

Did you deliver: **IN HOSPITAL** **AT HOME**

Did the delivery go as you had hoped/planned: **YES** **NO**

Did your labour begin: **NATURALLY** **IT WAS INDUCED** **BY PLANNED C-SECTION**

How did your waters break: **NATURALLY** **WITH INTERVENTION BY MIDWIFE**

What was the baby's presentation at birth:

HEAD FIRST (CEPHALIC) **HEAD FIRST (BACK TO BACK)** **BREECH**

ANY OTHER DETAILS REGARDING THE PRESENTATION PLEASE EXPLAIN HERE:

Approximately how long was the first stage of labour (the dilation stage)?

Did you move about much during this stage?

Approximately how long was the second stage (the pushing stage)?

What position were you in when the baby was delivered?

Were there any problems with the third stage (delivery of the afterbirth): **YES** **NO**

Did you have any pain relief: **YES** **NO**

IF YES PLEASE DESCRIBE:

Was the baby stuck at any stage: **YES** **NO**

Were any instruments used during delivery: **FORCEPS** **VENTOUSE** **OTHER**

Were there any problems during the delivery?

Post Delivery Stage

What was the baby's APGAR score (if known):

At 1 minute: (1-10) At 5 minutes: (1-10)

Approximately how long was it before the baby was given to you?

Within the first 30 minutes, did the baby cry: **YES** **NO**

Within the first 30 minutes, did the baby suck: **YES** **NO**

Was there anything in particular that you noticed about the baby's head: **YES** **NO**

IF YES PLEASE DESCRIBE:

Did the baby's head shape change during the first 24 hours: **YES** **NO**

During the first week, did the baby settle between feeds: **YES** **NO** **SOMETIMES**

Feeding & Sleeping

How are you currently feeding your baby:

BREAST FEEDING **BOTTLE FEEDING** **MIX OF BREASTFEEDING AND BOTTLE FEEDING**

If bottle feeding, which type of formula:

HAVE YOU EXPERIENCED ANY FEEDING DIFFICULTIES:

Has your baby been gaining weight well:

YES, ALWAYS **NOT ALWAYS** **HE/SHE HAS HAD PROBLEMS WITH GAINING WEIGHT**

At what age were solid foods introduced:

Has your child had any problems with their bowels?

How is your child's sleep?

How quickly was a sleep routine established?

Vaccinations

Which of the following vaccinations, and how many doses, has your child/baby had to date:

No vaccines given to date (skip to next question on page 7)

6-in-1 Vaccine (Diptheria, Hep.B, Hib, Polio, Tenatus, Whooping Cough):

NONE **1ST DOSE** **2ND DOSE** **3RD DOSE**

Rotavirus Vaccine:

NONE **1ST DOSE** **2ND DOSE**

MenB Vaccine:

NONE **1ST DOSE** **2ND DOSE** **3RD DOSE**

Pneumococcal (PCV) Vaccine:

NONE **1ST DOSE** **2ND DOSE**

MMR Vaccine:

NONE **1ST DOSE** **2ND DOSE**

Hib/MenC:

NONE **1ST DOSE**

Flu Vaccine: **YES** **NO**

HPV Vaccine: **YES** **NO**

MenACWY: **YES** **NO**

4-in-1 Preschool Booster: **YES** **NO**

3-in-1 Teenage Booster: **YES** **NO**

Any other vaccines given, or different vaccine schedule followed?

IF SO, PLEASE PROVIDE DETAILS:

Did your child/baby have any adverse reactions to any vaccinations: **YES** **NO**

IF YES, PLEASE PROVIDE DETAILS:

Illnesses

Has your child/baby had any illnesses? (including infections and any medication given):

Medication

Is your child/baby currently taking any medication? (including skin applications/creams):

Has your child/baby taken any medication in the past?

Accidents

Has your child/baby ever had any accidents? Please include any major or minor falls, broken bones or road traffic accidents (Please include approximate dates)

Has your child/baby ever been admitted to hospital? i.e. to casualty, for tests, treatments or operations (Please include approximate dates)

Dental History

Has your child/baby had any dental problems/required dental or orthodontics treatment:

Other Treatments

Please detail any other treatments your child/baby has undergone, such as homeopathy, occupational therapy, physiotherapy etc.:

School or Nursery

Please provide the name of your child/baby's school or nursery and let us know whether there is anything special about it:

Development

If your child/baby has already reached any of the following milestones, please write the approximate age they started to:

HOLD THEIR HEAD UP:

SIT WITHOUT SUPPORT:

CRAWL:

WALK:

TALK:

POTTY TRAIN:

Movements and favourite positions (have you noticed any asymmetries or difficulties – i.e. always looking to one side or a change in head shape?)

Family general health/illnesses worth noting (parents, grandparents, aunts and uncles)

Is there a family history of any of the following:

Asthma Eczema Hayfever Diabetes

PLEASE PROVIDE ANY ADDITIONAL DETAILS HERE

Does anyone in your household smoke: **YES** **NO**

If yes, how many cigarettes per day for each smoker?

Are there any pets in the house:

Please use this space if there is anything else you would like to mention before your visit. Thank you.