PRIMARY SCHOOL AGE MEDICAL HISTORY FORM (5-12 YEARS)

Please ensure you have completed a Patient Contact Details Form prior to completing this Medical History Form for your Child.

Name *your full name*

Date of Birth *dd/mm/yyy*

What is your child's main problem? *max 300 characters*

When did it start? *max 300 characters*

What do you consider caused this problem? *max 300 characters*

Has this problem occurred before and if so when? *max 300 characters*

At the onset of the problem, did your child experience any trauma, illness/infection or other significant event? *max 300 characters*

Are your child's symptoms worse at night or any specific time of day? *max 300 characters*

What relieves your child's problems? *max 300 characters*

What makes your child's problems worse? *max 300 characters*

Has your child had any other treatment for the current problem? *max 300 characters*

if so, what was the diagnosis? *max 300 characters*

Who was the practitioner? *optional*

Did you find the treatment effective?	○Yes ○ No

Please rate the severity of your child's symptoms: *10 being the most severe pain (circle one)*

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Has your child had any form of surgery or hospitalisation? *If yes, please detail*

Is your child currently taking any form of medication? *If yes please list medications.*

Does your child have any other illness, past or present? *If yes, please detail*

Has your child had any broken bones, accidents or significant injuries? *No matter how trivial please describe details*

Child's siblings *Please list name, age, sex and relationship to the child (Full/ Half Adopted/ Step)*

Do any of the siblings have medical problems?

Pregnancy: *Please indicate yes/no to the following*	Yes	No
Did you smoke during your pregnancy?	☐	☐
Did you drink alcohol during your pregnancy?	☐	☐
Did you take any medication during your pregnancy?	☐	☐
Where there any complications with the pregnancy or birth?	☐	☐
Was a caesarian section performed?	☐	☐
Did your baby have any bruises or birthmarks?	☐	☐

Where there any other complications during your child's birth?

What was your child's APGAR Score? *At 5 minutes*

Health & Development: Please indicate yes/no to the following	Yes	No
More than two episodes of otitis media (ear infection)	☐	☐
Ventilatory (myringotomy) tubes (grommets)	☐	☐
Visual difficulty	☐	☐
Movement problems	☐	☐
Poisoning or drug overdose	☐	☐
Sleep problems	☐	☐
Hearing difficulty	☐	☐
Poor growth weight/weight gain/failure to thrive	☐	☐
Convulsions/seizures/epilepsy	☐	☐
Difficulty talking	☐	☐
Toe walking	☐	☐

Health & Development: *(Continued)*	Yes	No
Eating or swallowing problems	○	○
Toileting problems	○	○
Tics or unusual movement	○	○
Run or walk more awkwardly than other children	○	○
Headaches not relieved by medication	○	○
Headaches in the middle of the night or upon awakening	○	○
Lost once- attained skills (language, motor)	○	○
Bed wetting beyond the age of 5 years old	○	○
Soiling beyond the age of 3 years old	○	○

How old was your child when he/she first sat alone? *estimate*

How old was your child when he/she first crawled? *estimate*

How old was your child when he/she first stood alone? *estimate*

How old was your child when he/she first walked without assistance? *estimate*

How old was your child when he/she first showed hand preference? *estimate*

Which hand does your child prefer?

How old was your child when he/she began to use words?

How old was your child when he/she was toilet trained? *Bladder*

How old was your child when he/she was toilet trained? *Bowel*

Does your child *(please indicate yes/no)*	Yes	No
Have difficulty finding the correct words to use in conversation	○	○
Have difficulty getting the correct word out	○	○
Put words in the wrong order	○	○
Confuse words with similar sounds	○	○
Have difficulty pronouncing words or sounds	○	○
Hesitate or stop before completing a sentence	○	○
Have a stutter	○	○
Understands what is said to him/her	○	○
Understands stories read to him/her	○	○
Talk about events happening or what he/she is doing	○	○
Relay a short message	○	○
Make good eye contact	○	○
Exhibit affection spontaneously	○	○
Enjoy playing with others	○	○
Flap arms when excited or stressed	○	○

Does your child have difficulty with the following tasks: (please indicate yes/no)		
Reading (word identification, comprehension, phonics)	○	○
Spelling (oral, written)	○	○
Writing (legibility, speed, sentence construction, grammar)	○	○
Maths (memory of basic facts, concepts)	○	○
Organisation (completing class work, homework, morning routine)	○	○
Reasoning and problem solving (personal or in school)	○	○
Sports	○	○
Coordination	○	○
Team work	○	○

What skill or ability does your child seem to excel in?

Do you have any other concerns about your child?

I consent for information about my child to be communicated to my GP and/or other relevant health professionals where appropriate.
○ I give consent ○ I do not give consent