

# Babies' Questionnaire

For new born babies and children up to 4 years of age

Before you bring your child to see us it would be most helpful if you would complete the following questionnaire and bring it with you to your first appointment. This will enable us to make the best use of the time available, as well as enabling us to avoid subjects that you may not wish discussed in front of your child.

<b>CHILD'S NAME</b>	
<b>MALE/FEMALE</b>	
<b>DATE OF BIRTH</b>	
<b>BIRTH WEIGHT</b>	
<b>AGE NOW</b>	
<b>BIRTH WEIGHT</b>	
<b>WEIGHT NOW</b>	

<b>NAME OF PARENT/GUARDIAN</b>	
<b>ADDRESS</b>	
<b>TELEPHONE NUMBER</b>	
<b>MOBILE NUMBER</b>	
<b>EMAIL ADDRESS</b>	If you are happy to receive information about the practice, please give your email address above.

<b>GP's NAME</b>	
<b>ADDRESS</b>	
<b>TELEPHONE NUMBER</b>	

<b>HOW DID YOU FIND OUT ABOUT US?</b>	
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<b>IS THERE ANY SPECIAL REASON WHY YOU ARE BRINGING YOUR CHILD/BABY?</b>	
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## MOTHER

<b>WHAT WAS YOUR AGE DURING THIS PREGNANCY?</b>	
<b>DID YOU HAVE ANY PROBLEMS?</b>	
<b>DID YOU TAKE ANY MEDICATION?</b>	
<b>DID YOU TAKE/ARE YOU STILL TAKING VITAMIN D?</b>	
<b>WHAT TESTS DID YOU HAVE?</b> Ultrasound, amniocentesis, etc.	
<b>WAS THE BABY IN A NORMAL POSITION DURING THE PREGNANCY?</b>	
<b>WAS THE BABY ENGAGED IN THE PELVIS?</b>	
<b>IF YES, TO WHAT EXTENT</b> 1/5 → 5/5	

## DELIVERY

<b>WAS YOUR BABY BORN ON THE DUE DATE?</b>	
<b>WAS THE DELIVERY AS YOU HOPED?</b>	
<b>WHEN DID THE CONTRACTIONS START?</b>	
<b>WHEN DID THE WATERS BREAK?</b>	
<b>WHEN WAS THE BABY BORN?</b>	
<b>DESCRIBE IN YOUR OWN WORDS THE DELIVERY AND BIRTH</b> Include details of pain relief, forceps/vacuum pump, etc.	

## AFTER THE DELIVERY

<b>WAS THE BABY INTUBATED?</b>	
<b>HOW LONG WAS IT BEFORE THE BABY WAS GIVEN TO YOU?</b>	
<b>APGAR SCORE 1 MINUTE</b>	
<b>APGAR SCORE 5 MINUTES</b>	
<b>DID THE BABY CRY OR SUCKLE WITHIN THE FIRST 30 MINUTES?</b>	
<b>DID YOU NOTICE ANYTHING PARTICULAR ABOUT THE BABY'S HEAD?</b>	
<b>DID THE HEAD CHANGE A LOT DURING THE FIRST 24 HOURS?</b>	
<b>IS THERE ANYTHING ELSE THAT YOU THINK IS IMPORTANT ABOUT THIS TIME?</b>	

## FEEDING

<b>BREAST OR BOTTLE?</b>	
<b>IF BOTTLE, WHICH FORMULAS HAVE YOU TRIED?</b>	
<b>HAVE YOU TRIED DAIRY FREE?</b>	
<b>ANY DIFFICULTIES WITH FEEDING?</b>	
<b>WEIGHT GAIN</b>	
<b>WHEN WERE SOLIDS INTRODUCED?</b>	
<b>WHAT DID THE BABY EAT? Likes/Dislikes</b>	
<b>WAS/IS THERE ANY PROBLEM WITH THEIR BOWELS?</b>	

## SLEEPING

<b>SLEEPING</b>	
<b>ANY PROBLEMS SLEEPING?</b>	

## MEDICAL HISTORY

<b>VACCINATIONS</b> Mark those applicable	Diphtheria Polio Tetanus HIB (meningitis) Whooping cough MMR
<b>ANY PROBLEMS FOLLOWING VACCINATIONS?</b>	
<b>ALLERGIES</b>	
<b>ILLNESSES</b> (Including medication if you know it)	
<b>HOSPITAL ADMISSIONS</b> Casualty/tests/treatments/operations	
<b>MEDICATION</b>	
<b>ACCIDENTS</b>	
<b>DENTAL HISTORY</b>	
<b>HAS THE CHILD SEEN A CHIROPODIST?</b>	

## FAMILY HISTORY

<b>PARENTS</b> Any history of illness/allergy Flat feet/knee, hip or spinal deformity	
<b>BROTHERS &amp; SISTERS</b> Birth weights/any health problems/similarities or differences to the patient	
<b>FAMILY GENERAL HEALTH</b> Parents/grandparents/aunts Uncles/cousins	

**The Data Protection Act** ('The Act') lays down certain requirements for the protection against unauthorised disclosures of personal information. The Act also gives you certain rights. The information which you give in this form, and any other information obtained during the course of your treatment, is on a strictly confidential basis. This information will be used solely for the purposes of providing osteopathic and/or any related treatment. We will not disclose any personal information which we hold about you outside this practice without your explicit consent, except to the extent we are required or permitted by law.

**Data Protection Policy** Jane O'Connor & Associates uses a database to hold certain information from the patient questionnaire. This information is entered into a database and so technically stored. The Form requires Opt-In Consent to add you to our mailing and text messaging lists.

- We will never give/sell or rent this data onto a third party.
- We may add your email address to our Jane O'Connor & Associates mailing list and your mobile telephone number to our Text Local appointment reminder list.
- Who has access to your personal data: Jane O'Connor & Associates, Text Local.
  - Website. We use Google Analytics on this site.
- You can lodge a data subject access request: You can email us at any time to remove your personal data from our systems. joconnor.osteopath@virgin.net
- How long will we hold your personal data:
  - We are required to retain adult patient notes for eight years following the last appointment
  - We are required to retain infant and child notes until that child reaches 25 years of age.

**GDPR Consent**

**Tick box for consent**

*I consent for The Osteopathic Practice to store my personal data.*

**Email Consent**

*I consent to be added to The Osteopathic Practice Mailing List.*

**Mobile Phone Number Consent**

*I consent to be added to The Osteopathic Practice (Text Local) to receive appointment reminders*

**Signed**

(If the patient is a child, the signature of the parent or legal guardian)

**Print name**

**Date**

## Cranial Osteopathy

Cranial Osteopathy is a gentle balancing technique that is commonly used on infants and small children. Because of its gentle nature, there are very few side effects with Cranial Osteopathy. Some babies may become either, sleepy or excited after a cranial treatment. This can last from a few hours up to a day.

**I have read the above and understand that, occasionally, there may be some unavoidable and temporary side effects resulting from my baby's/child's treatment at The Osteopathic Practice. I understand that signing this form does not affect my statutory rights.**

**I consent to my child having Cranial Osteopathy**

**Signed** \_\_\_\_\_

**Date** \_\_\_\_\_

(If the patient is a child, the parent or legal guardian must sign)

