Medical History: Bayside Kinesiology Learning Enhancement Acupressure Program

The following questions are part of the background necessary to evaluate your child's learning problems. A number of factors involved with the prenatal, birth and early postnatal periods are sometimes associated with learning difficulties in school aged children. Please fill in the following questionnaire, ticking where necessary the record of your child's development. If an item requires comment, or if a ticked item asks for comment, please give a brief, concise comment on that item
as it relates to your child's development.

Please briefly indicate if any of the listed items below apply to your child and note any that are not included in this list.

Mother: Prenatal, Perinatal – Postnatal Experience.				
Date of Birth:				
Sickness of any kind?	Yes		No	
Please describe				
	Description			
Viruses?				
Toxaemia?				
Accidents? eg. falls etc.				
Anything requiring medical attention of any kind during or as a result of pregnancy or birth.				
Other				
If you have separated or remarried in this child's lifetime how old was your child?				
Is there access/regular visits to the other parent? Is this stressful?				

<table>
<tr><td>Moved house or school? If so, what ages?</td><td colspan="7"></td></tr>
<tr><td colspan="8"></td></tr>
<tr><th colspan="8">Child's Birth:</th></tr>
<tr><td>How long was the labor?</td><td colspan="7"></td></tr>
<tr><td>Any drugs used during labor?</td><td colspan="7"></td></tr>
<tr><td colspan="8">Was there any difficulty in the birthing process? (eg. cord around neck, posterior presentation, foetal distress, forceps)</td></tr>
<tr><td colspan="8"></td></tr>
<tr><td colspan="8">Oxygen problems at birth, baby bluish or cord around neck not presented to mother immediately?</td></tr>
<tr><td colspan="8"></td></tr>
<tr><td>Foetal distress at birth?</td><td colspan="7"></td></tr>
<tr><td>Caesarian?</td><td></td><td>Complications?</td><td colspan="5"></td></tr>
<tr><td>Speed of Delivery</td><td>1st Stage</td><td></td><td>2nd Stage</td><td colspan="4"></td></tr>
<tr><td>Forceps Used / Suction Used</td><td>Yes</td><td></td><td>No</td><td colspan="4"></td></tr>
<tr><td>If Forceps, do you know where?</td><td>High</td><td></td><td>Mid</td><td></td><td>Low</td><td colspan="2"></td></tr>
<tr><td colspan="8">(Location of marks on head: High - above ears, Mid - at level of ears, Low - below ears.)</td></tr>
<tr><td>APGAR Score</td><td>………./10</td><td colspan="6">(Measures: 1. Heart Rate, 2. Reflex Response, 3. Colour, 4. Tone, 5. Respiration)</td></tr>
<tr><td>Was your baby removed for a period before presentation to you?</td><td>Yes</td><td></td><td>No</td><td colspan="4"></td></tr>
<tr><td>If yes, for how long?</td><td colspan="7"></td></tr>
<tr><td>Was there a period of extended separation? eg. premature</td><td colspan="7"></td></tr>
<tr><td>Any time spent in humidicrib?</td><td></td><td>If yes why & how long?</td><td colspan="5"></td></tr>
<tr><td colspan="8"></td></tr>
<tr><td colspan="8">Any other difficulty involved with the birth, or immediate post natal period?</td></tr>
<tr><td colspan="8"></td></tr>
<tr><td>Mother Medical Treatment</td><td colspan="7"></td></tr>
</table>

Any other complications?	
Father Support/Involvement	

Child's Growth and Development:

1. Has your child suffered any serious childhood diseases, had any operations, or other medical problems. Please describe briefly:

2. Has your child ever had "glue ear"?	Yes		No	
3. If yes, were grommets required?	Yes		No	

4. Does your child have any allergies that you are aware of? (please tick)

Pollen		House dust, house dust mite	
Food colorings, dyes or preservatives		Which ones (please list)	
Chemicals, e.g. petrol fumes, perfumes, cigarette smoke?		Which ones (please list)	
Allergies or intolerances of any foods?		Which ones (please list)	

5. Does your child suffer from Asthma?

Yes		No		Medicated?	

Type of Asthma medication?	
Which and How often?	

6. Taking medication of any kind for any reason?	
Which and for what condition?	

7. Has your child ever been knocked unconscious?	Yes		No	
If yes, for how long and under what circumstances?				

8. Has your child ever had an epileptic fit?	Yes		No	
If yes, describe				

9. Has your child ever suffered Febrile Seizures (high temperature induced fits or seizures) especially between 18 months & 3 years?	Yes		No	
If yes, please describe.				

10. When did your child start to crawl?	
Did they crawl normally, that is opposite hand and knee, or did they tend to scoot along on their bottoms or drag/extend one leg, or push forwards only with their arms, or other - describe?	
How long did they crawl?	
Did they just go from sitting or holding onto things to walking with little crawling?	

11. When did your child start talking?	
When did your child start saying:	

First Words?		First short sentences?	

Was there any verbal language delay?	Yes		No	
If yes, how long?				

12. Vaccinations? (see list last page)	Yes		No	
Any reactions?				

13. Child's Temperament ***(please tick where appropriate)***							
Happy		Aggressive		Bewildered		Moody	
Angry		Depressed		Withdrawn		Dreamy	

14. Age Started School		Repeated any grades?	

15. Siblings?

Name	***Age***	***Age of client when sibling born***

16. Has your child (even if still in the womb) experienced other trauma, time of high stress, grief in the family or abuse; emotional, sexual or physical? Ages when?

17. History of exposure to the following: Antibiotics; Anaesthetics; Painkillers.
18. Any other information you may feel is relevant?

Vaccination Schedule

New Born	Vit K oral/injection, Hepatitis B	5 years	CDT (childhood Dip, Tetanus, Sabin, Rubella)
6-8 weeks & 4, 6 & 18 months	Triple Antigen (diphtheria, whooping cough, tetanus). Polio Sabin	10-16 years	Rubella
2 months	HIB, PRP flu PRP (improved)	15 years	Adult Tetanus, diphtheria, Hepatitis B
12-15 months	Measles, Mumps, Rubella	Random	Flu, chicken pox, malaria, dysentery type vaccines, tetanus.

Table 1. Developmental Sensory History questions.

Question/ Category

Maternal Health During Pregnancy[1]

Did the mother:

Have any infections/illnesses during pregnancy? If yes, please describe[1]

Have any shocks or unusual stresses during pregnancy? If yes, please describe[1]

Receive any medication during pregnancy? If yes, what kind[1]

Have any complications during delivery/labor? If yes, please describe

Child’s Birth

Was the child full term?[1]

Was the child premature?

Weight at birth[1]

Number of weeks[1]

Was the child breech (feet first)?

Did the child require forceps for delivery?[1]

Did the child require suction for delivery?[1]

Did the child have any birth injuries?[1]

Did the child require intensive care hospitalization?

Was the child jaundiced?[1]

Early Childhood Illnesses and Injuries

Has your child had any of the following? If yes, please describe and give approximate dates.

Childhood disease or major illnesses

Serious injury

Ear infections

Tubes in ears[1]

Allergies

Seizures, for how long and what type - Grand Mal or Petite Mal

Other

Infancy and Childhood

Does or did your child:

Have feeding problems? If yes, please describe

Have sleeping problems? If yes, please describe

Have colic? If yes, for how long?[1]

Prefer certain positions as an infant? If yes, please describe[1]

Dislike lying on stomach?[1]

Dislike lying on back?[1]

Enjoy bouncing?[1]

Become calmed by car rides or infant swings?[1]

Become nauseated by car rides or infant swings?[1]

Go through the “terrible two”? If no, please describe your child’s toddler stage[1]

Developmental Milestones

Please provide approximate ages if remembered, or comment on anything unusual:

Roll Over

Walk

Say words

Sit alone

Say sentences

Crawl

Was crawling phase brief?[1]

Was crawling stage absent?[1]

Did child experience hesitancy or delays in learning to go down stairs?[1]

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[1]These questions were missing from the adult developmental sensory history.