Sage health and Wellness
12 Irwin avenue, suite 200
Toronto, ON
M4Y 1K9
Telephone: 416-926-8794
Email: sage@sagehealthandwellness.com

Osteopathy Assessment Form

For children under 24 months of age

CONTACT DETAILS

Child's first name:_____
Child's last name:_____
Parent name : _____
Address:_____
Postal code:_____
Occupation:_____

Mobile tel.:_____
Home tel.:_____
Work tel.:_____
E-mail :_____
Date of birth :_____
Age :_____

Permission to discuss your child's care and treatment with other health care providers?
Yes :_____ No :_____ Initial :_____

Reason for today's visit :_____

For patient's under 16 years of age, the signature off a parent/guardian is reguired:
I give consent for _____to receive Osteopathic treatment.
Name of parent/guardian: _____Signature: _____

Child's Health & Lifestyle

Has any other treatment been sought for this complaint? Yes / No _____
Have there been any tests/scans/x-rays for this complaint?_____
Does the child have any medical conditions? Yes / No :_____
If so, please give details :_____
Is the child receiving immunizations? Yes / No
Please list current medications including médications, vitamins/supplements and anti-inflammatory : _____
Does the child have regular sleeping patterns? Yes / No : _____
Do they prefer turning their head to one side? Yes / No
If yes, Left or Right (please circle)
Has the child been hospitalised or had any surgery or traumas (including broken bones & sprains) or car accidents? If so, please give details including dates :_____
Does the child have any medical implants or prosthesis (pacemaker, metal pins, etc) ? _____
Does the child have any allergies? Please give details : _____
How old was the child when they began: (if applicable) : _____
Crawling _____ Walking_____ Toilet Training _____
Does the child show any behavioural problems? Yes / No
If so, please give details :_____

In the past 6 weeks, has the child experienced:

Chest pain_____
Cough/Wheeze _____
Weight loss or weight gain_____
Blood or mucus in the stool_____
Headaches_____
Fainting_
Fevers or Chills _____
Change in bladder habits_____
Vomitting_____

Shortness of breath/Trouble breathing_____
Heart palpitations/irregular pulse_____
Increased thirst_____
Fatigue_____
Dizziness_____
Breath holding_____
Change in bowel habits_____
Abdominal pain_____

Birth Details:

Were there any medical problems during the pregnancy?
If so, please give details. _____
_____
At how many weeks was the baby born? _____
What was the delevery by : vaginal birth_____ or caesarian_____
If caesarian, why?_____
Was the child in the breech position?_____
Were forceps or suction used? _____
Birth weight:_____ Birth length: _____
APGAR score 1min _____ 5min _____
Was the baby kept in hospital longer than the mother? Yes /No
If so, please give details :_____
_____

Is/was the baby breastfed? Yes / No
For how long? _____
Is/was the child bottle fed? Yes / No
For how long? _____
If yes, Any reactions? _____
Following the birth, did the baby have any of the following:
Jaundice _____ Antibiotic treatment_____ Rash_____ Blue Spells_____Convulsions_____

Mothers only:

How many pregnancies have you had?_____ How many children have you had? _____
Are you currently pregnant? Yes / No When are you due?_____
Have you had any complications with previous pregnancies?_____
If so, please give détails :_____
_____

Family History:

Please circle any family history of the following (and who had the condition):

Cancer
Asthma
Incontinence
Diabetes
Kidney disease
Heart disease
Migraine
Urinary infections
Thyroid disease
Mental Disorder (including depression)
Circulation problems
Liver disease/Hepatitis Epilepsy/Seizures
Arthritis
HIV/AIDS

Any other Significant family history?_____
_____

Terms and conditions:

The therapy service and subsequent treatment program we devise for you is based upon our sound teaching practice and the information you have provided about yourself when filling out this medical screening questionnaire. You must therefore inform us about any change in your medical condition as soon as you become aware of it. I accept the above terms and conditions and agree to abide by them:

Signed:_____

Date:_____