

**INTAKE FROM CHILDREN FROM 2-15 YEARS OLD**

**What is the main complaint of your child?**

|  |
| --- |
|  |

Furthermore, there are also a number of questions. At the end there is still room to tell your story, if you want. With your child it is regarded as (put an x (cross) next to what applies to your child):

|  |  |  |  |
| --- | --- | --- | --- |
|  | Eczema/dry skin |  | Stomach ache |
|  | Difficulties with drinking/eating |  | Difficulties with stool |
|  | Restless behavior |  | Frequent headaches |
|  | Difficulties with sleeping |  | Regularly angry / sad |
|  | Frequently ill |  | Tired |
|  | Stays small / lagging growth |  | Bed wetting |
|  | Otherwise……… |

With your child it is regarded as:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Frequent change in emotions |  | Many friends |
|  | Comfortable in their own skin |  | Easily startled |
|  | Anxious |  | Curious |
|  | Poor concentration |  | Has learning disabilities |
|  | Slow/lazy |  | Restless/lively |
|  | Slow development |  | Prefers playing alone |
|  | Has behavioral problems |  | Easily tired |
|  | Inexhaustible |  | Is potty trained |
|  | Is not potty trained |  | behaves older than their age |
|  | Behaves younger than their age |

Does your child have ear infections regularly?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child have hearing impairment?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child have ear tubes?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child always breath through the mouth?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child often have a cold?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Did your child ever fall (as a baby or child)?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does you child fall regularly?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Has your child ever experienced a car accident / fall from a tree/horse/playground equipment or something else?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child have a scoliosis/bend or lop-sided back?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

**Nutrition and stool:**

|  |  |
| --- | --- |
|  | The stomach of your child feels hard |
|  | Your child has a poor appetite |
|  | Your child barely drinks water |

|  |  |  |  |
| --- | --- | --- | --- |
|  | The stool is daily |  | The stool is not daily |
|  | Hard stool |  | Mushy stool |
|  | Watery stool |

The color of the stool is

|  |  |  |  |
| --- | --- | --- | --- |
|  | Dark brown |  | Light brown |
|  | Yellow-brown |  | Green |
|  | White |

|  |  |  |  |
| --- | --- | --- | --- |
|  | The belly button sticks out |  | Your child has an umbilical hernia (fracture of the belly button) |

|  |  |
| --- | --- |
|  | Your child has a groin rupture |
|  | Left |  | Right |

|  |  |
| --- | --- |
|  | Your child has a fracture of the diaphragm |

|  |  |
| --- | --- |
|  | Your child has not been vaccinated yet |
|  | Your child has been vaccinated … times |

And responded

|  |  |  |  |
| --- | --- | --- | --- |
|  | Normal |  | With a lot of sleep |
|  | Restless |  | With fever |
|  | With a lot of crying after the vaccination. |
|  | Otherwise ………… |

**Are there familial diseases / disorders?**

|  |
| --- |
|  |

**Does your child suffer from allergies? Which one(s)?**

|  |
| --- |
|  |

**Does your child suffer from eczema? Where?**

|  |
| --- |
|  |

**History**The conception took place via:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Spontaneously |  | IVF (In Vitro Fertilization) |
|  | IUI (IntraUterine Insemination) |  | Ovum donation |
|  | Otherwise……….. |

Your child has been born:

after ... weeks

|  |  |  |  |
| --- | --- | --- | --- |
|  | Spontaneously |  | Planned |
|  | Cesarean |  | The birth had to be obstructed temporarily by clamping of the legs |
|  | Obstruction of the umbilical cord |

With use of implements/tools/remedies:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Labor induction |  | (kiwi) vacuum extraction or forceps delivery |
|  | Pressure on your abdomen |  | Your child has been pulled |
|  | Epidural |

The position of your child during labor was

|  |  |  |  |
| --- | --- | --- | --- |
|  | Normal (vertex presentation) |  | Mento-posterior presentation (flexed) |
|  | Cephalic presentation (face first) |  | Breech presentation (legs or bottom first) |
|  | Umbilical cord around the neck |

After birth your child was:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Normal |  | Too small |
|  | Yellow |  | Blue |
|  | Deformed head |
|  | Otherwise……….. |

Your child had a sound scream after birth

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

**What has made your child the most ill?**

|  |
| --- |
|  |

**Here is space where you can describe the history of diseases from your child (such as a fracture of the collarbone, an operation, infections, familial disorders or a specific history of diseases in a hospital):**

|  |
| --- |
|  |

Thank you for your time and effort!

Team Osteopathy Verstraten

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