

Pediatric Chiropractic Case History

Date: ___/___/___ No. _____

Patient Name _____ Birth-date ___/___/___

Address _____

City/State _____ Zip _____ Home Phone _____

How were you referred to our office? _____

Name of Parent or Guardian: _____

Phone of Parent or Guardian: Home: _____ Cell: _____

Work: _____ Other: _____

Email: _____

Age _____ Sex: Male Female Height _____ Weight _____ Handedness: Right Left Ambidextrous

Present M.D. and City _____

Date of last M.D. visit: ___/___/___ Reason: _____

Previous D.C. and City _____

Date of last D.C. visit: ___/___/___ Reason: _____

Authorization for Care of a Minor

I hereby authorize _____ and whomever they may designate to administer care as they deem necessary to my son/daughter.

Signed: _____

Witnessed: _____

Dated this _____ day of _____, 20____.

Chief Complaint

The reason you contacted us is _____

Date of onset: ___/___/___ Onset was : Sudden Gradual

Duration of (problem) (episode) _____ Min. Hrs. Days Months Years

Pattern of (problem) Constant Intermittent Occasional

Initiating factors: _____

Exacerbating factors: _____

Diminishing factors: _____

List all therapies or treatment undergone for this complaint (including medication): _____

Any concern with body function and daily activities: _____

Any impacts or stresses of any kind child has been through? _____

Any other health issues: _____

Prenatal History

Duration of gestation: _____ weeks. Pregnancy normal? Yes No

List any complications during pregnancy: _____

Position of baby during pregnancy _____

List any complications of delivery: _____

Did mother have back pain during birth? Yes No What was the position of baby at birth? face up face down

List any medication used during pregnancy: _____

List any medication used during delivery: _____

Forceps used for delivery? Yes No Place of birth: Home Hospital Birthing Center Vacuum extraction? Yes No

Apgar score at birth: _____ Apgar score at 5 min.: _____ Weight at birth: _____ Length at birth _____

Medication History

Antibiotics? Yes No How many? _____ Most recent _____

Other medications to treat what (how often each)? _____

Vaccinations taken? _____

Developmental History

Was the infant alert and responsive within twelve hours of delivery? Yes No

If "No", please explain: _____

At what age did the child:

Respond to sound: _____ Sit alone: _____ Follow an object with his/her eyes: _____

Hold head up: _____ Crawl: _____ Stand: _____ Walk alone: _____

Nutritional History

Breastfed: _____ months Formula began age _____ for _____ months Type of formula used: _____

Cow's milk began at age _____ Other milk: _____ began age _____ for _____ months

Began solid food at age _____ months Commercially prepared baby foods used? Yes No

Type : _____

Food/Juice Intolerance? Yes No Type: _____

Any Food allergies? _____

Social Behavior

Seems normal for age: Yes No If "No", please explain: _____

Childhood Diseases

Has your child had any childhood illness? (measles, mumps, chicken pox, whooping cough, strep, bronchitis, pneumonia) _____

Other Significant Data

List any significant family history: _____
