PEDIATRIC CASE HISTORY

DELIVERY/BIRTH HISTORY: _____

_____

_____

_____

AT WHAT AGE DID THE CHILD:

RESPOND TO SOUND _____ FOLLOW AN OBJECT WITH HIS/HER EYES _____ HOLD HEAD UP _____

SIT ALONE _____ CRAWL _____ STAND _____ WALK ALONE _____

AT WHAT AGE, IF EVER, DID THIS CHILD SUFFER FROM THE FOLLOWING CHILDHOOD DISEASES?

CHICKEN POX _____ MUMPS _____ MEASLES _____ RUBELLA _____ RUBEOLA _____

WHOOPI NG COUGH _____ OTHER _____

HAS THIS CHILD EVER SUFFERED FROM?

☐ HEADACHES	☐ ORTHOPEDIC PROBLEMS	☐ DIGESTIVE DISORDERS	☐ BEHAVIORAL PROBLEMS
☐ DIZZINESS	☐ NECK PROBLEMS	☐ POOR APPETITE	☐ ADD/ADHD
☐ FAINTING	☐ ARM PROBLEMS	☐ STOMACH ACHES	☐ RUPTURES/HERNIA
☐ SEIZURES/CONVULSIONS	☐ LEG PROBLEMS	☐ REFLUX	☐ MUSCLE PAIN
☐ HEART TROUBLE	☐ JOINT PROBLEMS	☐ CONSTIPATION	☐ GROWING PAINS
☐ CHRONIC EARACHES	☐ BACKACHES	☐ DIARRHEA	☐ ALLERGIES TO _____
☐ SINUS TROUBLE	☐ POOR POSTURE	☐ DIABETES	☐ ALLERGIES TO _____
☐ ASTHMA	☐ SCOLIOSIS	☐ HYPERTENSION	☐ ALLERGIES TO _____
☐ COLDS/FLU	☐ WALKING TROUBLE	☐ ANEMIA	☐ OTHER _____
☐ COLIC	☐ BROKEN BONES	☐ BED WETTING	☐ OTHER _____

HAS THIS CHILD EVER SUFFERED THE FOLLOWING SPINALTRAUMAS?

☐ FALL IN BABY WALKER	☐ FALL FROM BED OR COUCH	☐ FALL OFF SKATEBOARD OR SKATES
☐ FALL FROM CRIB	☐ FALL OFF SWING	☐ FALL OFF BICYCLE
☐ FALL FROM HIGHCHAIR	☐ FALL OFF SLIDED	☐ FALL DOWN STAIRS
☐ FALL FROM CHANGING TABLE	☐ FALL OFF MON KEY BARS	☐ OTHER _____

HAS THIS CHILD EVER SUSTAINED AN INJURY PLAYING ORGANIZED SPORTS? _____

IF YES, PLEASE EXPLAIN: _____

_____

HAS THIS CHILD EVER SUSTAINED INJURIES IN AN AUTO ACCIDENT? _____

IF YES, PLEASE EXPLAIN: _____

_____

PRESENT HISTORY: _____

_____

_____

_____

SURGERY: _____

MEDICATIONS: _____

ACCIDENTS: _____

FAMILY HISTORY: _____

PEDIATRIC PATIENT INTRODUCTION

CHILD'S NAME: _____ MOTHER'S NAME: _____

CASE NUMBER: _____ FATHER'S NAME: _____

ADDRESS: _____ CITY/TOWN: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ EMAIL: _____

MOTHER'S WORK PHONE: _____ MOTHER'S CELL PHONE: _____

FATHER'S WORK PHONE: _____ FATHER'S CELL PHONE: _____

BIRTH DATE: ____/____/_____ AGE: _____ SEX: _____ NUMBER OF SIBLINGS: _____ REFERRED BY: _____

BIRTH WEIGHT: _____ BIRTH LENGTH: _____ CURRENT WEIGHT: _____ CURRENT LENGTH: _____

THIRD TRIMESTER PRESENTATION: VERTEX _____ BREECH _____ TRANSVERS _____ FACE/BROW _____

TYPE OF BIRTH: NORMAL VAGINAL _____ FORCEPS _____ CESAREAN _____ SUCTION CAP OR VACUUM _____

LOCATION: HOME _____ BIRTHING CENTER _____ HOSPITAL _____

PROBLEMS DURING PREGNANCY: _____

PROBLEMS DURING LABOR/DELIVERY: _____

APGAR SCORES: _____ WAS THERE PRESENCE AT BIRTH OF: JAUNDICE (YELLOW)? _____CYANOSIS (BLUE)? _____

CONGENITAL ANOMALIES/DEFECTS? _____ IF YES,PLEASE EX PLAIN? _____

INFANT FEEDING: BREAST _____ BOTTLE _____ IF BOTTLE, WHICH FORMULA? _____

NUMBER OF HOURS SLEEPING PER NIGHT: _____ QUALITY OF SLEEP: GOOD _____ FAIR _____ POOR _____

OBSTETRICIAN / MIDWIFE: _____

PEDIATRICIAN / FAMILY MD: _____

DATE OF LAST VISIT: ____/____/_____ PURPOSE: _____

IMMUNIZATION HISTORY: _____

NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN: DURING THE PAST SIX MONTHS _____ DURING HIS/HER LIFETIME _____

PREVIOUS CHIROPRACTOR: _____

DATE OF LAST VISIT: ____/____/_____ PURPOSE: _____

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS? _____ IF YES, PLEASE EXPLAIN: _____

PURPOSE OF THIS APPOI NTMENT: _____

INSURANCE/BILLING INFORMATION: _____ POLICY #: _____

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

SIGNED: _____ WITNESSED: _____ DATE: _____/_____/_____

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE AND I ACREE TO PAY FOR ALL SERVICES PROVIDED. X-RAYS REMAIN THE PROPERTY OF THIS OFFICE.

SIGNED: _____ DATE: _____/_____/_____