

Pediatric Case History

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____ Date of Birth: _____ Age: _____

Mother's Name: _____ Father's Name: _____

Home Phone: _____ Work Phone: _____ E-mail: _____

Has your child ever received Chiropractic Care? Yes No If yes, Dr. _____ Year: _____

How did you hear about our office? Referred by _____

Other _____

Are you here only for a free scoliosis screening or spinal exam? Yes No

1. Birth Process - crushing or tearing injuries of the newborn's spine are prevalent in the birth process.

Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery long?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery difficult?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Forceps/Caesarean/Vacuum Extraction	_____
<input type="checkbox"/>	<input type="checkbox"/>	Breach/Cephalic?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Home birth?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospital birth	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mother given drugs during delivery?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was labor induced?	_____

2. Growth and Development

Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	Taught how to care for spine?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did child fall out of bed?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Headbanger or rocker?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Breast fed?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Formula?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Childhood sicknesses?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Accidents?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Surgery?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fell while learning to walk?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Picked on by siblings?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Child abuse?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Spanking (how)?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pulled ear / chin?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chair pulled out when sat down?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Yanked by arm?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fell down stairs?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Any other traumas?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Any broken bones?	_____

3. Dietary Habits

Fruits _____
Grains: Refined _____
Infant Milk: Human _____
Frequency of eating _____
Types of snacks _____

Vegetables Unrefined _____
Goat _____

Protein Cow: 2% / Whole _____

Sugar Formula _____

4. Temperament and Social Interaction

5. Symptoms and Ill Health

List your child's chief complaints in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

What activities aggravate the condition / pain? _____

What activities lessen the condition / pain? _____

List other doctors consulted for this condition:

1. _____ Address _____
2. _____ Address _____

Other symptoms your child has experienced (in the past or currently):

- | | | |
|-----------------------------------------|--------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Asthma | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Strep throat | <input type="checkbox"/> Fainting | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Sleeping problems | |

Has the child been under drug and medical care? _____ Surgery? _____

Please list with dates: _____

What medications is he/she taking? (Include antibiotics, inhalers, tylenol/aspirin, pain medications, allergy medications, etc.) _____

_____ How long? _____

What adverse side effects has the child experienced from the drugs and surgery? _____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>