CHILDREN'S CASE HISTORY

Patient History

Name_____ Date_____

Address_____ Postal Code_____

Cell Phone (Parent) _____ W. Phone_____

Date of Birth_____ Age_____ Referred by_____

Has your child ever received Chiropractic Care? Yes / No

Please circle for each of the following:		Patient Comment If answer is Yes	Chiropractor's Comments
1. Regarding the Birth Process:			
Was the delivery long/difficult?	Y N	_____	_____
Forceps or extraction used?	Y N	_____	_____
Cesarean/ C-Section?	Y N	_____	_____
Breach/ cephalic?	Y N	_____	_____
Home birth?	Y N	_____	_____
Hospital birth?	Y N	_____	_____
Mother given drugs during delivery?	Y N	_____	_____
Was labor induced?	Y N	_____	_____
2. Growth and Development/ Childhood:			
Breast fed?	Y N	_____	_____
Childhood illnesses?	Y N	_____	_____
Ear infections/ Colic/ Asthma?	Y N	_____	_____
Attention Deficit?	Y N	_____	_____
Antibiotics?	Y N	_____	_____
Drugs:	Y N	_____	_____
Colic?	Y N	_____	_____
Hospitalizations?	Y N	_____	_____
Sports or other physical activities	Y N	_____	_____
Injuries during sports?	Y N	_____	_____
Auto accidents?	Y N	_____	_____
Did they have other traumas?	Y N	_____	_____
Did they ever break any bones?	Y N	_____	_____
Eye problems?	Y N	_____	_____
Hearing problems?	Y N	_____	_____
Do they sleep well, hours of sleep?	Y N	_____	_____
Sleeping posture? O side O stomach O back		_____	_____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my child's health.
I agree to allow this office to examine my child for further evaluation.

Parent/Guardian Signature_____Date_____