Case # _____

CHILD'S CASE HISTORY
(Age 12 and Under)

ABOUT YOUR CHILD ...

Dear Parent(s),

Welcome! We will do our very best to provide your child with any chiropractic care needed. In order to do this, please answer the following questions as completely as possible. Take your time. It is an important part of the initial evaluation of your child.

Please keep in mind that, although some of these questions are medically oriented, we do not provide medical care. However, we do need to know what your child's history is in order to accurately determine the need for chiropractic care.

This is a family chiropractic center. We look forward to your child joining the "family"!

I. General Information

Today's Date: _____

Child's Full Name: _____ _____ _____
First Middle Last

What name do you want us to call your child? _____

Mother's Name: _____ Mother's Phone: (H)_____ (W) _____

Father's Name: _____ Father's Phone: (H)_____ (W) _____

Mailing Address: _____ City _____ State _____ Zip _____

Date of Birth: Month _____ Day _____ Year _____

Present Age: Years _____ Months _____ Sex: ☐ Female ☐ Male

Child's Social Security Number: _____ - _____ - _____

How did you find out about us? ☐ **Referral** If referred, by whom? _____

☐ **Sign** ☐ **Yellow Pages** ☐ **Other** _____

II. Mother's Pregnancy History

Was your child carried full term? ☐ **Yes** ☐ **No** If no, how long? Months _____ Weeks _____

Were ultrasounds taken? ☐ **Yes** ☐ **No** Have there been side effects? ☐ **Yes** ☐ **No**

If yes, what? _____

Did you take any drugs during the pregnancy? ☐ **Yes** ☐ **No** Have there been side effects? ☐ **Yes** ☐ **No**

If yes, what? _____

III. Birth History

☐ **Single** ☐ **Twin** ☐ **Triplet**

Where was your child born? ☐ **Home** ☐ **Birthing Center** ☐ **Hospital**

Who delivered your child? ☐ **MD** ☐ **Midwife** ☐ **Spouse** ☐ **Other** _____

Type of birth? ☐ **Vaginal** ☐ **Cesarean**

Were any of the following used? ☐ **Forceps** ☐ **Vacuum Extraction** ☐ **Fetal Monitor**

Was the delivery long? ☐ **Yes** ☐ **No** If yes, how long? _____

Was the umbilical cord wrapped around the infant's neck? ☐ **Yes** ☐ **No**

Were there complications which may have injured the infant? ☐ **Yes** ☐ **No**

If yes, please explain _____

What position was your child in during delivery?

Head First: ☐ **Normal (face *down*)** ☐ **Anterior Presentation (face *up*)**

Other: ☐ **Breech (both feet delivered at the same time)** ☐ **Frank Breech (bottom first)**

☐ **Footling Breech (one first , as if infant doing a split)**

Were any of the following present at birth?

Congenital defects: ☐ **Yes** ☐ **No** If yes, what? _____

Cyanosis (blue): ☐ **Yes** ☐ **No**

Cuts, dents or bruises: ☐ **Yes** ☐ **No** If yes, please explain _____

IV. Drug History

Has your child been given antibiotics? ☐ **Yes** ☐ **No**

If yes, for what problem? _____

Has you child been given other drugs? ☐ **Yes** ☐ **No**

If yes, which ones? _____

Has your child been vaccinated? ☐ **Yes** ☐ **No**

If yes, were there reactions to the vaccinations? ☐ **Yes** ☐ **No**

If yes, please explain _____

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V. Early History

Feeding: ☐ Breast ☐ Bottle ☐ Both

Does /did the infant have digestive or elimination difficulties? ☐ Yes ☐ No

If yes, please explain _____

Does/did the infant have sleeping difficulties? ☐ Yes ☐ No

If yes, please explain _____

Does/did the infant have unusual crying spells? ☐ Yes ☐ No

If yes, please explain _____

Do/did you notice any position in which the infant seemed uncomfortable? ☐ Yes ☐ No

If yes, please explain _____

Does/did your child seem delayed in any area? ☐ Yes ☐ No

If yes, please explain _____

Can your child walk? ☐ Yes ☐ No

If yes, do/did you notice any problems with balance or position of feet? ☐ Yes ☐ No

If yes, please explain _____

Has your child taken any bad falls while learning to walk? ☐ Yes ☐ No

If yes, please explain _____

Does your child have tubes in the ears? ☐ Yes ☐ No

If yes, at what age were they put in? _____

Has your child had any other surgery? ☐ Yes ☐ No

If yes, please explain _____

VI. History of Injuries

Has your child broken any bones? ☐ Yes ☐ No

If yes, please explain _____

Has your child ever been knocked unconscious? ☐ Yes ☐ No

If yes, please explain _____

Is your child involved in a sport? ☐ Yes ☐ No

If yes, what _____

Has your child had any falls which may have injured the spine? ☐ Yes ☐ No

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If yes, please explain _____

Has your child been involved in a car accident? ☐ Yes ☐ No

If yes, at what age? _____

Was your child: ☐ wearing a seat belt? ☐ in a car seat?

Were x-rays taken? ☐ Yes ☐ No If yes, of what area? _____

Please describe any injuries _____

_____

Is there anything else you think we should know about your child's spine? ☐ Yes ☐ No

If yes, please explain _____

Please add any additional information that may be helpful. _____

_____

I have reviewed and certify that all the above information is true to the best of my knowledge.

Parent/Guardian Signature _____ Date _____