KEOUGH
CHIROPRACTIC

Child's Case History

Please Print

Patient Information

Child's Name _____ Date of birth _____

Mother's Name _____ Father's Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell phone _____

Email Address _____

Mother's History

Tell me about your prenatal time:

Did you exercise? ___Y ___N please explain _____

Did you drink alcohol? ___Y ___N please explain _____

Did you take drugs? ___Y ___N please explain _____

Did you eat regularly? ___Y ___N please explain _____

Did you have any spinal pain or problems during you pregnancy? ___Y ___N please explain

_____

Labor

How long was labor? _____

Was labor artificially induced? ___Y ___N

Would you say it was ___ Easy ___ Hard ___ very Hard

Did you have a spinal block / Epidural? ___Y ___N

How did you deliver the child? ___ on back ___ On all fours ___ Squatting ___ Sitting up in birthing chair ___other

Did the doctor grasp/pull on the child's head? ___Y ___N

Did you notice if the doctor twisted? ___Y ___N

Were forceps used? ___Y ___N

Do you remember the APGAR score? ___Y ___N If so, what was it? _____

Any complications? _____

Baby's History

Was this child breastfed? ___Y ___N How long? _____

Did this child have any unusual or strange habits or behaviors as a newborn?

_____

Child's Case History (cont.)

Please Print

Colic? ___Y ___ N

Fussy? ___Y ___N Alert? ___Y ___N Happy? ___Y ___N

Did child have shots (immunizations)? ___Y ___N

Did child crawl? ___Y ___N Beginning at what age? ___months

Was child in a walker? ___Y ___N How long? _____

For how long did the child crawl? _____

At what age did child begin to walk? _____

Did you notice anything unusual about the child's efforts to learn to walk? ___Y ___N

Did the child fall a lot? ___Y ___N

Were there any particularly hard falls that you recall? ___Y ___N

If so, please explain: _____

Young Child

Ear infections? ___Y ___N

Colds? ___Y ___ N

Mucus/Sinus trouble? ___Y ___ N

Falls? ___Y ___N

Collisions (Automobile)? ___ Y ___N

Anything else you have noticed about your child that you think is unusual:

_____

_____

List any medications, past or present:

_____

_____

Any diagnosed diseases:

_____

_____

Signature of Mother, Father, or Legal Guardian _____ Date _____

Patient Symptoms Questionnaire

Please Print

Patient Name: _____ Date: _____

Symptoms

1. What is your number-one problem or the one area of greatest pain? _____

_____

2. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt.

If your pain varies from day to day, please circle two numbers to indicate a range of your pain. **0 1 2 3 4 5 6 7 8 9 10**

3. When did this problem/pain start? _____ ____ Gradual ____ Sudden ____ Progressive

4. What do you think caused this problem? _____

5. How often do you experience the pain?

____ 1-2 hours per day ____ About half of the day _____ Most of the day ____ The pain never goes away

6. How does the pain affect your daily activities?

____ It does not affect my daily activities ____ I have had to change how I do things

____ I have had to stop doing some of my daily activities ____ I am unable to perform daily activities

7. What increases your pain? _____

8. What decreases your pain? _____

9. Have you ever experienced this problem before? **Y N** When? _____

10. List any other complaints currently bothering you and rate your pain level for each using the same scale as above.

a. _____ 0 1 2 3 4 5 6 7 8 9 10
b. _____ 0 1 2 3 4 5 6 7 8 9 10
c. _____ 0 1 2 3 4 5 6 7 8 9 10
d. _____ 0 1 2 3 4 5 6 7 8 9 10

If you have experienced any of the following conditions in the **past** mark a **"P"** on the line provided. If you are **currently experiencing** any of the following conditions please mark a **"C"** on the line provided. (check all that apply)

___ heart attack	___ stroke	___ arthritis	___ gall bladder trouble
___ diabetes	___ glaucoma	___ fainting spells	___ kidney stones
___ difficulty with urination	___ bloody stools	___ difficulty with bowel movements	
___ prostate trouble	___ anemia	___ cancer	___ asthma
___ AIDS	___ ulcers	___ diverticulosis	___ menstrual cramping
___ dizziness	___ loss of memory	___chest pain	___ shortness of breath
___constipation	___ diarrhea	___ general fatigue	___ sudden weight loss
___ nausea	___ muscle cramping	___ soreness in joints	___ loss of hearing
___ ears ringing	___ headache	___ migraine	___ epilepsy
___ gout	___ tuberculosis	___ syphilis	___ sprained ankle R L
___ knee/hip replacement		___ broken bones (specify) _____	

Patient Symptoms Questionnaire (cont.)

Please Print

Patient Name: _____ Date: _____

General Activities (check all that apply)

___ sleep on waterbed ___ read in bed ___ fall asleep in recliner/on couch
___ sleep on stomach ___ use two or more pillows to sleep with
___ needlepoint/knitting ___ sewing
___ lift weights/wt. mach. ___ play video games (___ hrs per day)
___ exercise ____x/wk ___ jog ___ x/wk ___ computer use (___ hrs per day)
___ swim ___ use elliptical ___ watch television (___ hrs per day)

Please add anything else you would like the doctor to know:
_____
_____
_____

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ Date _____
(signature of parent if the patient is a minor)

*Doctor's comments:*_____
_____
_____
_____
_____
_____

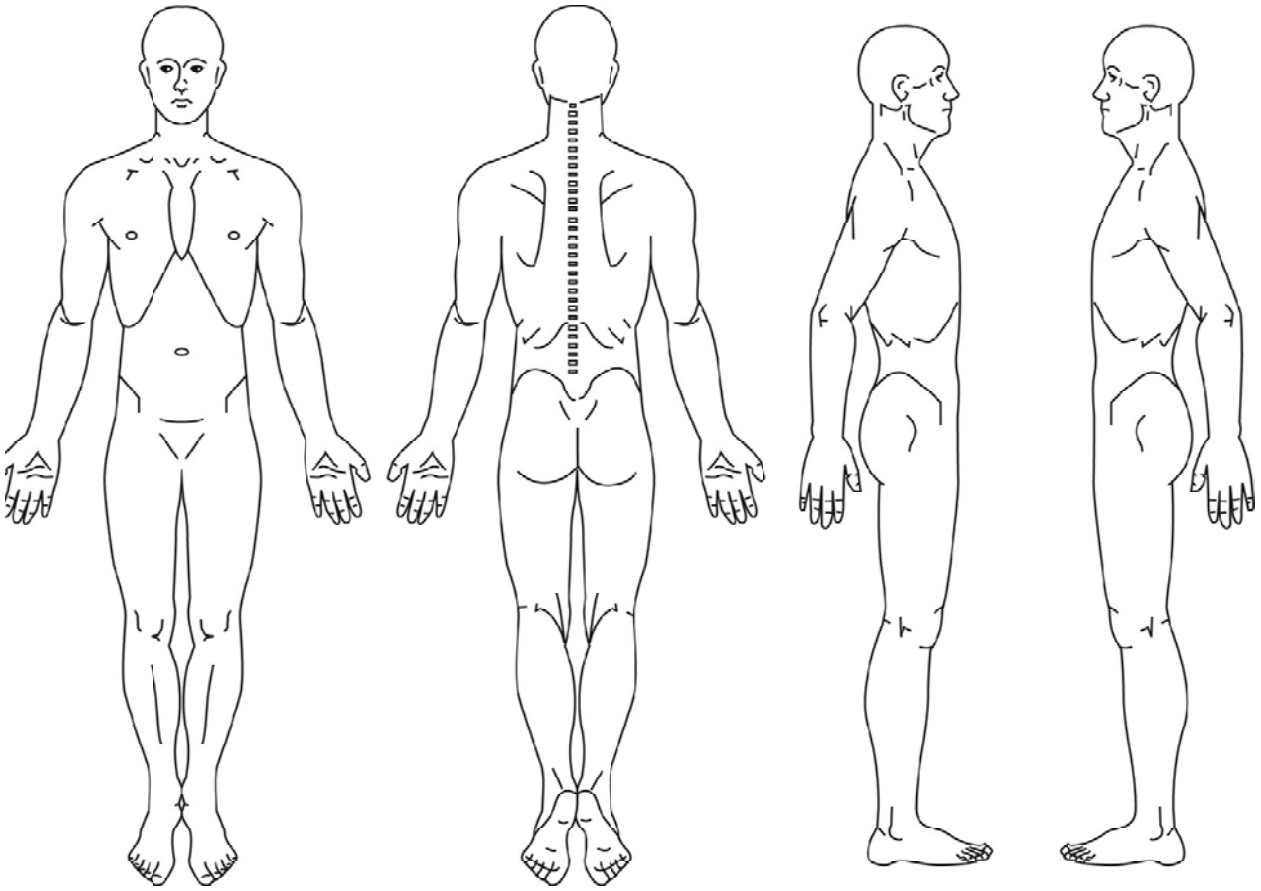
Pain Diagram

Please Print

Patient Name: _____ **Date:** _____

Please complete the following "Pain Diagram" by using the letters below to indicate on the diagram your areas of pain:

(P) Pain **(T) Tingling** **(N) Numbness** **(B) Burning** **(S) Stiffness**



Notes:

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