



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 _____ Referred By _____

Email Address _____ Insurance Company _____

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? _____

Birth Weight _____ Birth Length _____

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___Squ atting___Si tting 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)

- | | | |
|---|--|--|
| <input type="checkbox"/> sleep on waterbed | <input type="checkbox"/> read in bed | <input type="checkbox"/> fall asleep in recliner/on couch |
| <input type="checkbox"/> sleep on stomach | <input type="checkbox"/> use two or more pillows to sleep with | |
| <input type="checkbox"/> needlepoint/knitting | <input type="checkbox"/> sewing | |
| <input type="checkbox"/> lift weights/wt. mach. | <input type="checkbox"/> play video games (___ hrs per day) | |
| <input type="checkbox"/> exercise ___x/wk | <input type="checkbox"/> jog ___ x/wk | <input type="checkbox"/> computer use (___ hrs per day) |
| <input type="checkbox"/> swim | <input type="checkbox"/> use elliptical | <input type="checkbox"/> 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:

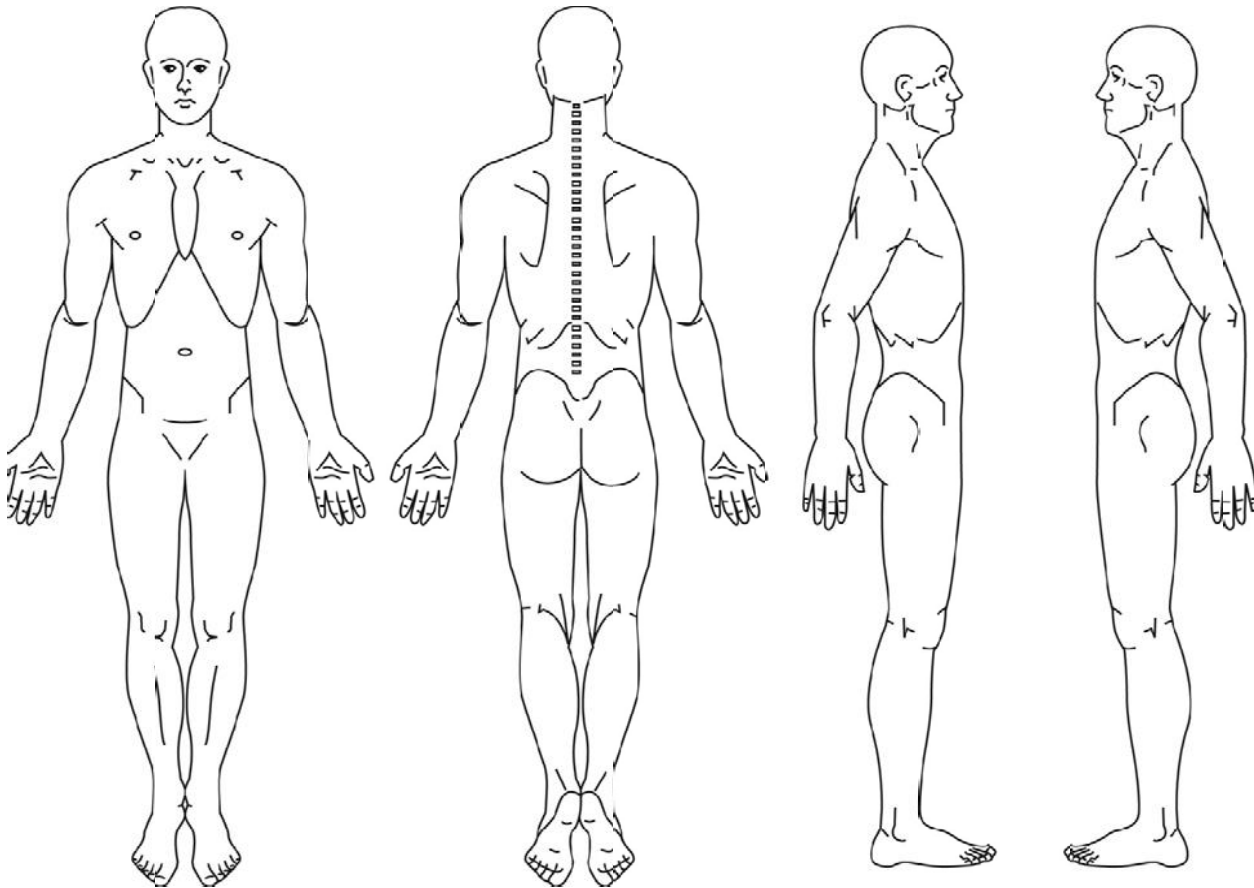
(P) Pain

(T) Tingling

(N) Numbness

(B) Burning

(S) Stiffness



Notes:
