

Children's Case History

PLEASE PRINT

Full Name: _____ Male Female Date: _____

Date of Birth: _____ Age: _____

Parent # 1 name: _____ Parent # 2 name _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Parent Work Phone # _____ Parent Cell Phone # _____

Parent E-mail Address: _____ Number of siblings & ages: _____

How did you hear about Family Chiropractic? Who can we thank for referring you _____

Is there a specific reason for consulting our office at this time? There is more room on the next page for additional writing.

Adoption Information

Child's age when adopted: _____ Date of adoption: _____

Known health history of child _____

Birth Information

Birth weight _____ Birth length _____ Apgar scores (if known): _____

Type of birth: Vaginal _____ Forceps _____ Breech _____ Cesarean _____ Home _____ Birthing Center _____ Hospital _____

Any problems during pregnancy and/or labor? There is more space on next page for additional information.

Jaundice (yellow) at birth? _____ Cyanosis (blue)? _____

Congenital anomalies/defects? _____

Infant feeding : Breast _____ Bottle _____ Formula _____ Other food or drink information? _____

Number of hours child sleeps daily _____ Quality of sleep: Good _____ Fair _____ Poor _____

Please explain: _____

Health and Medical Information

Obstetrician and/or Midwife name: _____ Location: _____

Pediatrician and/or Family Doctor name: _____ Location: _____

Date of last visit to doctor: _____ Purpose of that visit _____

Immunization history, if applicable: _____

Has your child ever been treated on an emergency basis? _____

Please describe _____

Purpose of the appointment today with the Chiropractor: _____

Mother's pregnancy history: _____

Delivery/birth history: _____

Developmental History

At what age did the child:

Respond to sound _____

Crawl _____

Follow an object with their eyes: _____

Hold Head Up _____

Stand _____

Sit Alone _____

Walk Alone _____

Childhood Diseases – Age of Child When Occurred:

Chicken Pox _____

Rubella _____

Rubeola _____

Whooping Cough _____

Mumps _____

Measles _____

Other _____

Has this child ever suffered from (please check any that apply):

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Neck Problems |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Backaches | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Allergies | <input type="checkbox"/> Orthopedic problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Sugar Concentration | <input type="checkbox"/> Headaches | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Leg Problems |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Joint Problems |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Chronic Earaches/infections | <input type="checkbox"/> Colds/Flu |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Muscle Jerking | <input type="checkbox"/> Ruptures/Hernias | <input type="checkbox"/> "Growing Pains" |
| <input type="checkbox"/> Any Other Problem: _____ | | | |

Present Health History or Additional Information: _____

Surgery Information: _____

Medications: _____

Accidents: _____

Family Health History: _____

Authorizaton for Care of a Minor

I HEREBY AUTHORIZE FAMILY CHIROPRACTIC OF KENNEBUNK AND ITS DOCTOR(S) TO EXAMINE AND ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY CHILD (UPON APPROVAL OF PARENT OR GUARDIAN).

X _____
PARENT/GUARDIAN SIGNATURE(S) DATE