Confidential Child Case History

Date _____Child's Name _____❑ Male ❑ Female

Date of Birth: _____ Age _____

Parent/Guardian _____ No. Of Siblings _____

Address_____ City_____ Post Code_____

Phone: (H) _____ (cell) _____(W) _____

E-mail Address_____

Family Doctor_____Location_____

How were you referred to our office? _____

Extended Health Coverage

Health Insurance ❑ Yes ❑ No Company Name _____

Coverage per year _____ $ When does your coverage start? _____

Previous Chiropractic

Has your child ever received chiropractic care? ❑ Yes ❑ No

Reason for visit_____

Results of treatment: ❑ Excellent ❑ Good ❑ Fair ❑ No Help

Authorizing Consent for Examination of a minor (under age 16)

I do hereby request and consent to the performance of an evaluation by the chiropractor to make a determination of the suitability of my child's case for care.

Name _____ *Signature*_____

Witness _____*Date*_____

Chief Complaint Record

What is the reason for this visit:

❑ Specific concern _____
❑ Prevention/Wellness Check-Up: Early detection of problem

Other professionals seen for this condition? ❑ Yes ❑ No

Type of treatment? _____

Results of treatment? ❑ Excellent ❑ Good ❑ Fair ❑ No help

Has your child had these symptoms before? ❑ Yes ❑ No When?_____

When did the problem begin? _____

What caused your present symptoms? _____

How often does it occur? ❑ Occasional ❑ Frequent ❑ Constant

Are the symptoms getting: ❑ Worse ❑ Better ❑ No Change

What makes your symptoms better? _____

What makes them worse? _____

Does this problem interfere with: ❑ Sleep ❑ Eating ❑ Daily Routine ❑ Other

List any medication or surgeries _____

Are there any smokers in the home? ❑ Yes ❑ No Pets? ❑ Yes ❑ No

How many prescriptions of antibiotics in this last year? _____

How many prescriptions of antibiotics in their life time? _____

Other prescriptions taken this year _____

Vaccination History _____

Evolve Chiropractic Wellness Studio, Dr.Laura Lardi, 378 Plains Road East, Burlington ON

Many childhood illnesses can be due to misaligned vertebrae and pinched nerves.
Please check any your child is currently experiencing or has experienced in the past.

❑ Ear Infections
❑ Tonsillitis
❑ Asthma/Allergies
❑ Dizzy/Clumsy
❑ Constipation
❑ Colic
❑ Back Problems
❑ Bed Wetting
❑ Seizures
❑ Headaches
❑ Learning Difficulties
❑ Frequent Colds/Flu
❑ Scoliosis
❑ Difficulty Sleeping
❑ Digestive Problems
❑ Temper Tantrums
❑ ADHD/Behavioural
❑ Recurring Fever
❑ "Growing Pains"
❑ Other _____

Developmental History

Many childhood falls can produce long term spinal misalignments that may surface many years in life.

Has your child ever had a serious fall (i.e. from crib)? _____

Physical activities your child participates in _____

Any hospitalizations or surgeries? ❑ Yes ❑ No Explain _____

Does your child sleep on: ❑ Stomach ❑ Back ❑ Side

Do you consider your child's sleeping patterns normal? ❑ Yes ❑ No

Is a school back pack used? ❑ Yes ❑ No Is the backpack: ❑ Heavy ❑ Light

Nutrition & Feeding History

Was your child breast-fed? ❑ Yes ❑ No For how long? _____

Formula at what age? _____Type _____

Introduction of cow's milk at what age? _____Other milk? _____

Began solids at what age? _____ Any food allergies/intolerances? ❑ Yes ❑ No

Type of allergies/intolerance _____

How often does your child eat dairy, white sugar, gluten(flour), processed food?

❑Daily ❑ Nearly every meal ❑ few times per week ❑ Weekends ❑ Never

Prenatal History

Often birth trauma can produce first spinal problems in the delicate spine of a newborn:

Gestational age at birth? _____weeks Birth weight _____ Length_____

Child's birth process: ❑ Forceps ❑ Induced ❑ Vaginal ❑ Caesarean
❑ Breach ❑ Vacuum Extraction ❑ Spontaneous

Any evidence of birth trauma to the infant?

❑ Bruising ❑ Odd shaped head ❑ Stuck in Birth Canal
❑ Cord around neck ❑ Respiratory Depression ❑ Fast or long birth

Complications during pregnancy? ❑ Yes ❑ No Explain_____

Complications during labour/delivery? ❑ Yes ❑ No Explain_____

Did the mother smoke or drink during the pregnancy? ❑ Yes ❑ No

Traumas during pregnancy? ❑ Yes ❑ No Explain_____

Drugs and supplements taken during pregnancy? _____

Ultrasounds during pregnancy? ❑ Yes ❑ No How many? _____

Reasons for ultrasound_____

Any invasive procedures during pregnancy (ie amniocentesis)? ❑ Yes ❑ No

Medications or epidurals given to the mother during birth? ❑ Yes ❑ No

_____

Is there anything else we need to know about the birth?

Family History

Please tick if there is a family history of any of the following:

❑ Heart Disease
❑ Cancer
❑ Arthritis
❑ Stroke
❑ Diabetes
❑ High Blood Pressure
❑ Other _____