Below
CHIROPRACTIC & WELLNESS

CHILD CASE HISTORY

NAME____

DATE OF BIRTH____________________ MALE_________ FEMALE________

REASON FOR TODAY'S VISIT ____

Y N DOES YOUR CHILD COMPLAIN OF PAIN OR DISCOMFORT?

IF YES, WHEN DID THIS OCCUR? ______________________________

WAS ONSET SUDDEN _________ GRADUAL ___________

IS PROBLEM CONSTANT___________ INTERMITTENT ____________

Y N HAS YOUR CHILD EVER HAD THIS PROBLEM BEFORE?

Y N HAS YOUR CHILD PREVIOUSLY BEEN TREATED FOR THIS PROBLEM? BY WHOM? ____

Y N HAS YOUR CHILD PREVIOUSLY HAD CHIROPRACTIC CARE?

HEALTH HISTORY

Y N DOES YOUR CHILD EVER COMPLAIN OF BACK OR NECK PAIN?

Y N DOES YOUR CHILD EVER COMPLAIN OF PAINS IN THE ARMS OR LEGS?

Y N DOES YOUR CHILD EVER COMPLAIN OF HEADACHES?

Y N DOES YOUR CHILD HAVE ASTHMA?

Y N IS YOUR CHILD ALLERGIC TO ANYTHING?_____________________________

Y N ARE THERE ANY SMOKERS IN THE CHILD'S HOME?

Y N HAS YOUR CHILD HAD ANY HEADACHES? AT WHAT AGE DID THEY START?__________ HOW FREQUENTLY DO THEY OCCUR? ______________

IN WHICH EAR DO THE EARACHES USUALLY OCCUR? RIGHT LEFT BOTH

NAME ____

Y N HAS YOUR CHILD EVER HAD A PROBLEM WITH BED WETTING?

Y N IS YOUR CHILD CURRENTLY TAKING ANY MEDICATION?
____

PLEASE LIST ANY OTHER ILLNESS THAT HAVE BEEN A CONCERN FOR YOUR CHILD ____

LIST ANY SURGERIES YOUR CHILD HAS HAD ______________________________

TRAUMA

Y N HAS YOUR CHILD HAD ANY RECENT FALLS OR TRAUMA?
PLEASE DESCRIBE THE TRAUMA AND THE DATE IT OCCURRED
____

Y N HAS YOUR CHILD EVER FALLEN FROM STAIRS?

Y N HAS YOUR CHILD EVER BEEN IN A MOTOR VEHICLE ACCIDENT?

Y N HAS YOUR CHILD EVER HAD A BONE FRACTURE OR JOINT DISLOCATION? ____

Y N HAS YOUR CHILD HAD ANY OTHER TRAUMA OR INJURIES?
____

NUTRITION

Y N DO YOU HAVE CONCERNS ABOUT YOUR CHILD'S DIET?

Y N DOES YOUR CHILD HAVE ANY FOOD ALLERGIES?
____

Y N DOES YOUR CHILD TAKE VITAMIN SUPPLEMENTS?

Y N WAS YOUR CHILD BREAST FED? HOW LONG? ______________________

HOW OFTEN DOES YOUR CHILD EAT FAST FOOD? __________________________

HOW OFTEN DOES YOUR CHILD DRINK SOFT DRINKS? ______________________

WHAT TYPE OF SNACKS DOES YOUR CHILD EAT? __________________________

Signature of Parent or Guardian ___________________________________Date ________