Confidential Pediatric Patient Case History

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU!

Child's Name: _____ Date: _____
Date of birth: _____ Gender: _____
Mother's Name: _____ Father's Name: _____
Address: _____
City, State, Zip Code: _____
Home Phone: _____ Email Address: _____
Child's Social Security Number *(if known):* _____
Parent's Social Security Number *(just one):* _____
Who referred you to our office? _____
How else did you hear about us? _____

Birth Weight: _____ Current Weight: _____
Birth Length: _____ Current Length/Height: _____

Present Health:

What is your primary concern for your child's health? _____

If your child is experiencing a symptom, please answer the following:

1. When did it begin? _____
2. How did it happen? _____
3. How often does it affect your child? □constant □intermittent
4. Symptom severity is currently: □mild □moderate □severe
5. Symptom is currently: □increasing □decreasing □not changing
6. Symptom is worse in the: □morning □afternoon □night □same all day
7. What makes the symptom better? _____
8. What makes the symptom worse? _____
9. Have you seen another provider for this complaint? □yes □no
   If so, who: □Chiropractor □MD □Osteopath □Specialist □Other_____
   When and what was their treatment_____
10. How do your child's symptoms interfere with their lifestyle/ daily routine or with your family's lifestyle/ daily routine? _____

Any secondary concerns for your child? _____

Has your child suffered any injuries in the past? _____
Has your child been diagnosed with any disease or condition?_____
Do you have a family history of:

□heart disease □cancer □arthritis □diabetes □lung conditions □high blood pressure
□stroke/vascular problems □kidney or liver conditions □other_____

Anything else you would like the doctor to know about your child? _____
_____

Birth History: *(please check all that apply)*

□ Home	□ Forceps	□ Epidural Anesthesia
□ Birth Center	□ Vacuum	□ IV Anesthesia
□ Hospital	□ Normal (face down)	□ Oral Pain Drugs
□ Vaginal	□ Posterior occiput (face up)	□ Pitocin
□ Cesarean	□ Breech	□ Other drug/intervention: _____

Hours of labor: _____ Name of obstetrician/midwife: _____

Nutrition: *(please note the age/ length of time for each)*

Breastmilk _____
Bottle (pumped breast milk) _____
Formula _____

Solid Foods _____
Does your child use any nutritional supplements? _____

Medical Interventions:
Please list any prescription medications your child has taken in the last year:

_____
Please list any over- the- counter medications has your child taken in the last year:

_____
How many prescriptions of antibiotics has your child taken in the last year? _____
How many antibiotics in his/her lifetime? _____

Vaccination History *(please check those that apply)*
□ I have opted to not have my child vaccinated
□ My child has been partially vaccinated
Vaccines given: _____
Vaccines refused: _____
□ My child has been fully vaccinated
□ My child has be given a flu shot
Years given: _____

Has your child ever been hospitalized? _____
Has your child ever undergone a surgical procedure? _____

Name of pediatrician/ family MD: _____

Review of Systems: *Please indicate if you child has had any of the following symptoms or diagnoses in the past year or in their lifetime and any treatment they received for it.*

Past year:	Lifetime:		Treatment:
□	□	Ear Infections	_____
□	□	Chronic colds/cough	_____
□	□	Recurrent Fevers	_____
□	□	Asthma	_____
□	□	Allergies	_____
□	□	Colic	_____
□	□	Stomach/digestive problems	_____
□	□	Constipation	_____
□	□	Diarrhea	_____
□	□	Bed Wetting	_____
□	□	Seizures	_____
□	□	Rashes	_____
□	□	Scoliosis	_____
□	□	ADHD	_____
□	□	Learning Disorder	_____
□	□	Temper Tantrums	_____
□	□	Sleeping Problems	_____
□	□	Headaches	_____
□	□	Autism	_____
□	□	Other (please explain):	_____

Authorization for care of a minor: I hereby authorize this office and its Doctors to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent/guardian).

Parent's signature: _____ **Date:** _____