

PEDIATRIC CASE HISTORY

File# \_\_\_\_\_

Child's Name \_\_\_\_\_ Date \_\_\_\_\_
(Last) (First) (MI) (Preferred Name)

Street Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if other than above) Rural Route# \_\_\_\_\_ and/or P.O. Box \_\_\_\_\_ City \_\_\_\_\_

E-mail Address \_\_\_\_\_ Would you like to receive our e-mail newsletter? [ ] Yes [ ] No

Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: Male Female

Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ at \_\_\_\_\_ None

Does your child have Insurance with Chiropractic Benefits? No [ ] Yes [ ]

Subscriber \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_ Person responsible for account \_\_\_\_\_

Would you like to receive e-mail communication from our office? [ ] Yes [ ] No

Should you enjoy your experience with us and choose to refer friends or family, we want to reward you. Of the following, which type of gift card would you most appreciate? [ ] Target [ ] Lowes [ ] Starbucks

IN CASE OF EMERGENCY:

Relative or friend not living in your home \_\_\_\_\_ Phone \_\_\_\_\_

I clearly understand and agree that I am personally responsible for full payment of all services rendered to my child.

Parent/Guardian's Signature \_\_\_\_\_

Describe the current symptoms \_\_\_\_\_

How did the symptoms begin? \_\_\_\_\_

Is the pain or discomfort worsening? [ ] No [ ] Yes [ ] Same What, if anything, makes it worse? \_\_\_\_\_

Does the condition interfere with? [ ] Sleep [ ] Recreation [ ] Daily Routine \_\_\_\_\_

Has there been any previous treatment for this condition? Results? \_\_\_\_\_

Have any X-rays been taken? No [ ] Yes [ ] \_\_\_\_\_ Where? \_\_\_\_\_

Has a similar problem occurred in the past? No [ ] Yes [ ] \_\_\_\_\_

Any previous spinal injuries? No [ ] Yes [ ] \_\_\_\_\_

Are any medications currently being taken? No [ ] Yes [ ] \_\_\_\_\_

Any previous surgeries or hospitalizations? No [ ] Yes [ ] \_\_\_\_\_

Any complications during birth? No [ ] Yes [ ] Unknown [ ] \_\_\_\_\_

Other health issues or history: (Check all that apply)

- General Fatigue or Weakness, Fever (continuous), Loss of Sleep / Trouble Sleeping, Headaches, Dizziness / Fainting, Convulsions, Nervousness / Anxiety / Depression / Phobias, Allergies, Memory Loss or Impairment, Difficulty Concentrating, Nose / Sinus Symptoms, Ear pain / Trouble, Vision / Eye Trouble, Tonsillitis / Infected Tonsils, Skin / Nail / Hair changes, Heart Trouble or Chest Pain, Respiratory / Breathing, Change in Appetite, Abdominal Pain, Nausea/Vomiting, Gastrointestinal / Digestion, Urinary

[ ] None of the above-listed symptoms apply.

CA/DC Initials \_\_\_\_\_