

CONFIDENTIAL PEDIATRIC CASE HISTORY



Welcome to our office! Please read this form and answer all questions.

Child's Name: _____ M / F Siblings: _____

Address: _____ City: _____ Prov: _____ Postal Code: _____

Home Phone: _____ Date of Birth: _____ Email: _____
DD / MMM / YYYY

Name of Parents/Legal Guardians: _____ Referred By: _____
PLEASE PRINT

CHILDS HEALTH HISTORY

Purpose of this appointment: Spinal Check-up _____ Other: _____

Has this child (a) had previous chiropractic care? Yes / No (b) seen other Drs for this condition? Yes / No

Doctor(s)' Name & Prior Treatments: _____

Other Health Concerns: _____

Pertinent Family History: _____

Number of antibiotic doses your child has taken (a) In past 6 months _____ (b) In lifetime _____

Other Prescription Medications: Previously _____ Currently _____

Allergies/Intolerances: _____

Number of bowel movements per day: _____ Hours of sleep per night: _____

Have you chosen to vaccinate your child: Yes / No Reactions following vaccinations: _____

PRENATAL HISTORY Parent / Guardian comment if answer is YES Chiropractor's comments

Yes No
 Ultrasounds during pregnancy – Number _____

Complications during pregnancy _____

Complications during delivery _____

Medications during pregnancy or delivery – List: _____

Location of birth: Home Yes / No Birthing Centre Y / N Name: _____ Hospital Y / N Name: _____

Type of Delivery: Vaginal _____ Forceps _____ Vacuum Extraction _____ C-Section _____

Cigarette / Alcohol use during pregnancy: If so how much: _____

Genetic disorders: Please list _____

Developmental disorders or challenges: _____

Breast-fed How Long? _____ Formula-fed: Y / N How Long? _____

PAST HEALTH HISTORY

Has your child ever been in an automobile accident? Yes / No If yes when: Past year 2 to 5 years Over 5 years

Sports / recreational activities (List all) _____

List any injuries (falls, broken bones, concussions, etc.) _____

CONFIDENTIAL PEDIATRIC CASE HISTORY

PATIENT'S NAME: _____

Has your child ever been seen on an emergency basis? If yes why: _____

Hospitalization or surgery: _____

Check any of the following that apply to your child:

Asthma _____ Allergies _____ Hyperactivity _____ Bed-Wetting _____
Ear Infections _____ Skin Problems _____ Difficulty Sleeping _____
Colic _____ Constipation/Diarrhea _____ Nutritional Deficiencies _____
Insufficient physical activity _____ Other: _____

The above information is true and accurate to the best of my knowledge.

Print Child's Name: _____

Parent or Legal Guardian's Signature (s) _____

Parent or Legal Guardian's Signature (s) _____

Date Signed: _____ at _____
DD/MMM/YYYY CITY PROV.

Witness Name: _____ PLEASE PRINT Witness Signature: _____