Kimberton Chiropractic

Child and Adolescent Case History

Today's Date: _____

Patient's Name: _____ Patient's DOB: _____ S.S. #: _____

Address: _____

_____

Race (Circle): American Indian or Alaska Native / Asian / Black or African American/
White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Preferred Language: _____

Parent Name: _____

Parent's Cell: _____ Parent's Work: _____

Email: _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Parent Name: _____

Parent's Cell: _____ Parent's Work: _____

Email: _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

How did you hear about our office: _____

For Moms:

1. Tell us about your pregnancy:

Did you carry to full term? _____

Describe any complications and when they occurred: _____

_____

2. Tell us about your delivery and birth of this child:

Did you use a midwife? _____ Hospital? _____ Obstetrician? _____

Did you have a C-Section? _____ Forceps used? _____ Vacuum Extraction? _____

Were you induced? _____ Did you have an Epidural? _____ Was it a difficult birth? _____

3. Other health info:

Did you breastfeed? _____ How long? _____ Formula after? _____

Did you consume alcohol during your pregnancy? _____ How much? _____

Did you smoke? _____ How much? _____ How long? _____

Did you take any medication during your pregnancy? _____

For what? _____ What type? _____

Any exposures to ultrasound? _____ How many? _____

For Baby/Child:

1. As a baby/toddler, (birth to 4 years), did any of the following occur?

___ Fall from a changing table	___ Frequent crying spells	___ Reaction to vaccination
___ Tumble down stairs	___ Frequent fevers	___ Did not gain weight
___ Fall out of crib	___ Frequent bouts of diarrhea	___ Colic

___ Car accident
___ Fall off playground equipment
___ Play in a Jolly Jumper
___ Constipation
___ Sleeping problems
___ Frequent colds
___ frequent ear infections
___ Other_____

2. As a young child, (5-10 years), did any of the following occur?

___ Fall from a tree
___ Fall of a bicycle
___ Fall of playground equipment
___ Sports accident
___ Car accident
___ Bed wetting
___ Hyperactivity/Autism
___ Learning difficulties
___ Asthma
___ Allergies
___ Scoliosis
___ Leg/knee pains
___ Stomach pains
___ Other_____

3. Has your child had any vaccinations?: _____
Any reactions to any of these? _____

4. Any hospital stays or surgeries: _____

5. Current pain/problem: _____

6. Is this problem: Constant ___, Intermittent _____, Occasional _____, Cyclic _____

7. Current symptoms:

___ Headaches
___ Dizziness
___ Ringing in ears
___ Asthma
___ Hyperactivity
___ Fatigue
___ Numbness in arms/hands
___ Arm/wrist pains
___ Sleeping problems
___ Allergies
___ Stomach problems
___ Weight gain/loss
___ Foot/ankle/knee pains
___ Tingling in arms/legs
___ Neck/back pains
___ Shoulder pains
___ Growing Pains
___ Other _____

8. When did the problem start? _____

9. When is it at its worst? _____

10. What helps the problem? _____

11. What makes it worse? _____

12. What effect does this problem have of your child's daily activities?

_____

13. Have you done any home remedies? _____

14. Has your child seen any other doctors about this problem? _____

15. Did other doctors recommend any type of treatment/medications? _____
If Yes, what? _____

16. Is your child currently taking any medications? Yes / No

(Include regularly used over the counter medications)

Medication Name	Dosage (# of mg)	Frequency (Times a day)

17. Do you have any medication allergies? Yes / No

Medication Name	Reaction	Onset Date	Additional Comments