Case History

Pediatric

Child's Name ______________________ Date __________ S.S. # __________

Home Phone __________ Birth Date __________ Age ______ Sex: M F Grade __________

Street ______________________ City ______________ State ______ Zip ________

Who is accompanying this child ______________________ Relation __________ Custody Y / N

Home Phone (if different than child's) __________ Work Phone __________

Who should we call in an emergency? Name ______________________ Phone __________

Has this child ever received Chiropractic care? Y / N If yes where? ______________________

Family Health History

Please identify any health problems that any blood relatives have had.

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	Birth defects	☐	☐	Rheumatoid Arthritis	☐	☐	Heart Problems
☐	☐	Genetic defects	☐	☐	Muscle Disorders	☐	☐	Kidney Problems
☐	☐	Mental retardation	☐	☐	Skin Disease	☐	☐	Rheumatic Fever
☐	☐	Allergies	☐	☐	Eye or Ear Disorders	☐	☐	Tuberculosis
☐	☐	Lung disease	☐	☐	Cancer	☐	☐	Seizures/Convulsions
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Venereal Disease
☐	☐	Bone and joint disorders	☐	☐	Thyroid Disease	☐	☐	HIV/AIDS
						☐	☐	Other __________

About Your Child's Health

Throughout life, events occur which damage the body and reduce health. This is true during childhood as well as adulthood. Children are usually less aware of their body function than adults and often do not comment about a problem or do not know how to communicate their complaints. This case history will help uncover evidence of damage and malfunction, especially to the nerve system. Following the exam, Dr. Baker will outline a course of care to begin to correct the layers of damage and recover this precious child's health potential.

Early Factors that Affect Your Health - Mother's Health and Childbirth

Let's begin at birth when many people first damage their spines and nerve system and began their journey to ill health.

Yes	No	Don't Know	During the mother's pregnancy did she:
☐	☐	☐	smoke or drink alcohol?
☐	☐	☐	eat a healthy diet?
☐	☐	☐	exercise through pregnancy?
☐	☐	☐	experience any falls or injuries?
☐	☐	☐	experience any physical or mental abuse?

__________ Birth weight

Yes	No	Don't Know	During the birth process:
☐	☐	☐	Was the delivery long?
☐	☐	☐	Was the delivery difficult?
☐	☐	☐	Were forceps used?
☐	☐	☐	Was the birth caesarean?
☐	☐	☐	Was it a breach birth?
☐	☐	☐	Were medications used during birth?
☐	☐	☐	Was labor induced?

Childhood Habits and Events that Damage Health

Please check any of the following events that happened during childhood:

- ☐ Fall out of bed
- ☐ Fall while learning to walk
- ☐ Forcefully spanked
- ☐ Pulled by ear
- ☐ Pulled by arm
- ☐ Fall off bike
- ☐ Fall off playground equipment (Monkey bars, swings, teeter totter, etc)
- ☐ Chair pulled out when sat down
- ☐ Involved in car accident
- ☐ Fell out of tree
- ☐ Physical fight with siblings or others
- ☐ Sleep sitting in car
- ☐ Contact sports
- ☐ Skating injury

Other ______________________________

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Has your child ever had:

- ☐ Measles
- ☐ Rubella
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Whooping cough
- ☐ Rheumatic Fever
- ☐ Hepatitis
- ☐ Bronchitis
- ☐ Asthma
- ☐ Pneumonia
- ☐ Anemia
- ☐ Difficulty talking
- ☐ Stuttering
- ☐ Crossed or wandering eyes
- ☐ Vision problems
- ☐ Eye irritation
- ☐ Frequent headaches
- ☐ Frequent ear infections
- ☐ Hearing problems
- ☐ Sores in mouth
- ☐ Frequent sore throat
- ☐ Frequent nose bleeds
- ☐ Frequent sinus congestion
- ☐ Frequent tonsil infections
- ☐ Frequent ear infections
- ☐ Tubes in ears
- ☐ Difficulty breathing
- ☐ Repeated coughing
- ☐ Dizzy or fainting
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Difficulty walking/balancing
- ☐ Painful joints
- ☐ Sprains/broken bones
- ☐ Posture problems
- ☐ Skin problems
- ☐ Rashes
- ☐ Frequent stomach aches
- ☐ Frequent diarrhea
- ☐ Frequent constipation
- ☐ Frequent nausea
- ☐ Bed wetting problems
- ☐ Eaten paint or dirt
- ☐ Over tired
- ☐ Recurrent fever
- ☐ Behavior problems in school
- ☐ Seizures

Nutrition:

Was the child breast fed? ☐ Yes ☐ No, Months_____ Formula fed ☐ Yes ☐ No, Months _____ Formula __________

- ☐ Eats 5 or more fruits or vegetables
- ☐ Dairy products (milk, cheese, icecream)
- ☐ Takes vitamin supplements
- ☐ Drinks water daily
- ☐ Drinks soda daily
- ☐ Eats sugar cereal daily

List all medications the child has taken within the past 3 months: ______________________________

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Child's pediatrician: ______________________ Reason for last visit: ______________________

Current Health Complaints

In the next box, describe the child's major complaint

Complaint ______________________________

When did this problem start or when was the most recent occurrence: ______________________________

How often are the symptoms: ☐ Constant, or _______ X per ☐ day, ☐ week, ☐ month, ☐ year.

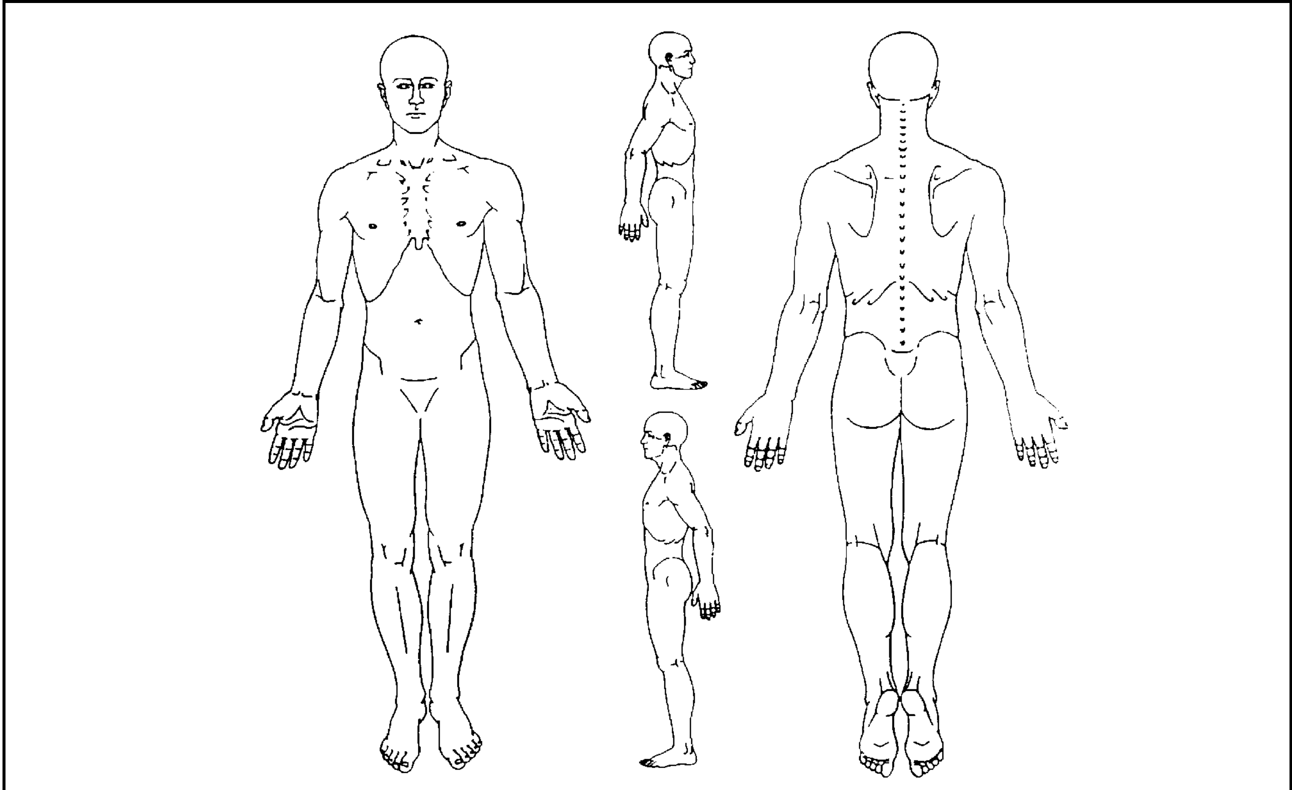
Has the child had similar symptoms in the past? Yes No ______________________________

What activities aggravate this condition ______________________________

Is this condition getting worse? Yes No ______________________________

Notes ______________________________

In the box below, please mark the areas of pain or other symptoms.



List other complaints: ____

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Doctor's use only ____

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I certify that the above information is correct to the best of my knowledge and I hereby authorize the doctor and his representatives to examine and treat my conditions as he deems appropriate. I understand that as a chiropractor, the doctor may find it necessary to treat the whole spine and extremities, and not necessarily the areas of complaint. I also authorize this office to acquire or share information about my or my child's case with other health care providers as they deem appropriate.

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Parent's or Guardian's signature Date