Child's Case History

Please Print

Patient Information **Acct#**______________

Child's Name ______________________ Date of Birth ____________

Mother's Name ______________________ Father's Name ______________________

Address ______________ City ______________ State ________ Zip Code ________

Home Phone: ______________________ Cell Phone: ______________________

Mother's History

Tell me about your prenatal time:

a. Did you exercise? ○ Y ○ N Please explain: ______________________

b. Did you drink alcohol? ○ Y ○ N Please explain: ______________________

c. Did you take drugs? ○ Y ○ N Please explain: ______________________

d. Did you eat regularly? ○ Y ○ N Please explain: ______________________

e. Did you have any spinal pain or problems during your pregnancy?
○ Y ○ N Please explain: ______________________

Labor

a. How long was your labor? ______________________

b. Was labor artificially induced? ○ Y ○ N

c. Would you say it was: ? ○ Easy ○ Hard ○ Very Hard

d. Did you have a spinal block? ○ Y ○ N

e. How did you deliver the child?
○ On back ○ On all fours ○ Squatting ○ Sitting up in a birthing chair ○ Other ______________________

f. Did the doctor grasp/pull on child's head? ○ Y ○ N
Did you notice if the doctor twisted? ○ Y ○ N
Were forceps used? ○ Y ○ N

g. Do you remember the APGAR score? ○ Y ○ N If so, what was it?______________________

h. Any complications? ______________________

____

Baby's History

a. Was this child breastfed? ○ Y ○ N How long? ______________________

b. Did this child have any unusual or strange habits or behaviors as a newborn? ______________________

c. Colic? ○ Y ○ N

d. Fussy? ○ Y ○ N c. Alert? ○ Y ○ N d. Happy? ○ Y ○ N

e. Did child have shots (vaccinations)? ○ Y ○ N

f. Did child crawl? ○ Y ○ N Beginning at what age? _________ months

g. Was a child in a walker? ○ Y ○ N How long? ____

h. For how long did the child crawl? ____

i. At what age did child begin to walk? ____

j. Did you notice anything unusual about the child's efforts to learn to walk? ○ Y ○ N
Did the child fall a lot? ○ Y ○ N
Were there any particularly hard falls that you recall? ○ Y ○ N
If so, please explain: ____

Young Child

a. Ear infections? ○ Y ○ N

b. Colds? ○ Y ○ N

c. Mucus/sinus trouble? ○ Y ○ N

d. Falls? ○ Y ○ N

e. Collisions (Automobile)? ○ Y ○ N

Anything else you have noticed about your child that you think is unusual: ____

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List any medications, past or present: ____

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Any diagnosed diseases: ____

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Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature ____ Date _________________
(signature of parent if the patient is a minor)

Synchrony ChiroCare
Harmony of Structure and Function

Pain Diagram

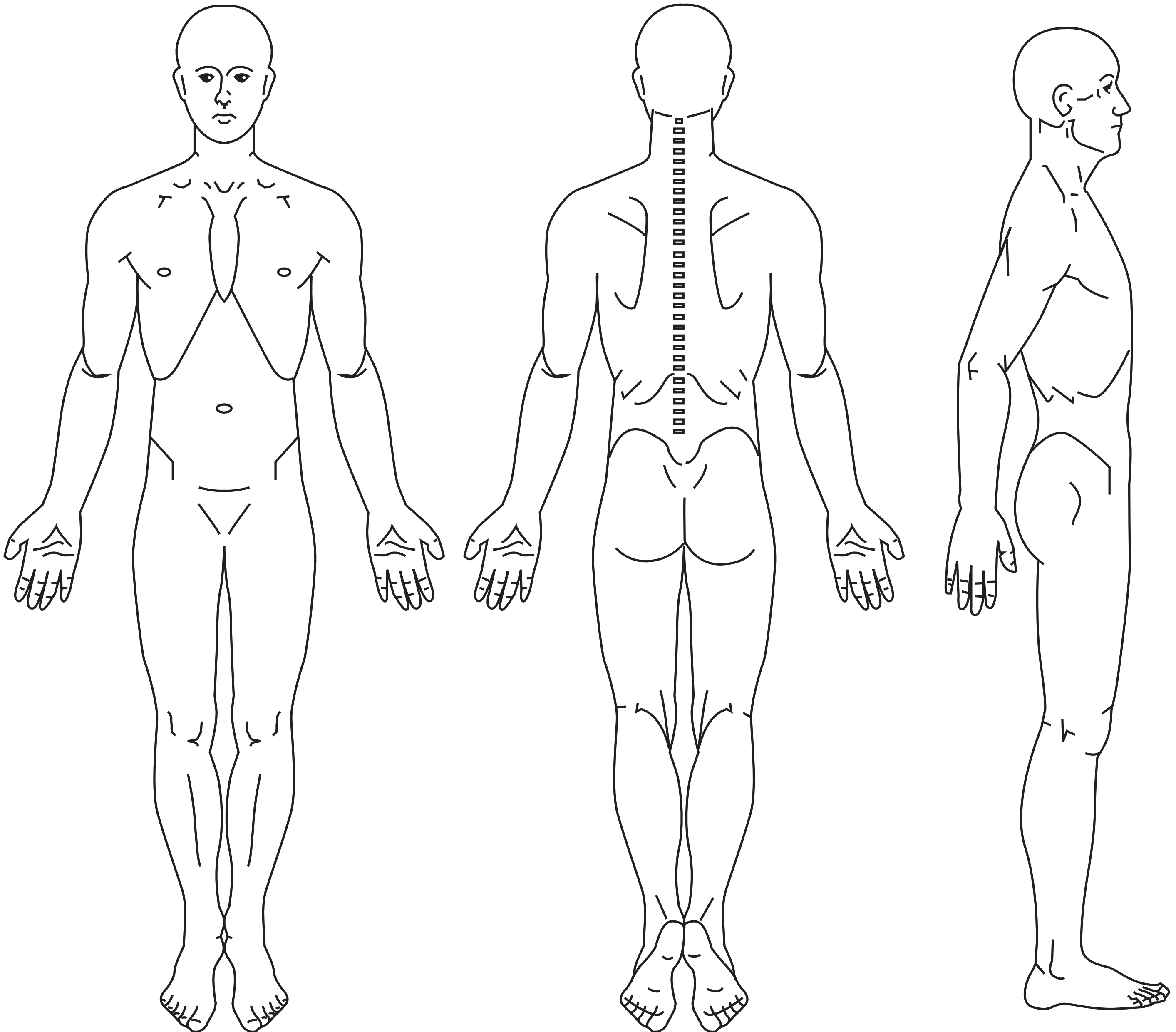
Please Print

Body Diagram Date Acct#

Last Name First Name

Please mark the diagrams according to where you experience your symptoms and pain using the following symbols:

X for Sharp Pain ***O*** Dull Ache */// *Burning Pain *** Numbness



Patient's Signature ______________________________ Date______________