

CHILD CASE HISTORY
2+ - 12 Years Old

DATE _____

NAME _____

DATE OF BIRTH _____ MALE _____ FEMALE _____

REASON FOR TODAY'S VISIT _____

Y N DOES YOUR CHILD COMPLAIN OF PAIN OR DISCOMFORT?

IF YES, WHEN DID THIS OCCUR? _____

WAS ONSET SUDDEN _____ GRADUAL _____

IS PROBLEM CONSTANT _____ INTERMITTENT _____

Y N HAS YOUR CHILD EVER HAD THIS PROBLEM BEFORE?

Y N HAS YOUR CHILD PREVIOUSLY BEEN TREATED FOR THIS PROBLEM? BY WHOM? _____

Y N HAS YOUR CHILD PREVIOUSLY HAD CHIROPRACTIC CARE?

HEALTH HISTORY

Y N DOES YOUR CHILD EVER COMPLAIN OF BACK OR NECK PAIN?

Y N DOES YOUR CHILD EVER COMPLAIN OF PAINS IN THE ARMS OR LEGS?

Y N DOES YOUR CHILD EVER COMPLAIN OF HEADACHES?

Y N DOES YOUR CHILD HAVE ASTHMA?

Y N IS YOUR CHILD ALLERGIC TO ANYTHING? _____

Y N ARE THERE ANY SMOKERS IN THE CHILD'S HOME?

Y N HAS YOUR CHILD HAD ANY HEADACHES? AT WHAT AGE DID THEY START? _____ HOW FREQUENTLY DO THEY OCCUR? _____

IN WHICH EAR DO THE EARACHES USUALLY OCCUR? RIGHT LEFT BOTH

Y N HAS YOUR CHILD EVER HAD A PROBLEM WITH BED WETTING?

Y N IS YOUR CHILD CURRENTLY TAKING ANY MEDICATION?

PLEASE LIST ANY OTHER ILLNESS THAT HAVE BEEN A CONCERN FOR YOUR CHILD _____

LIST ANY SURGERIES YOUR CHILD HAS HAD _____

TRAUMA

Y N HAS YOUR CHILD HAD ANY RECENT FALLS OR TRAUMA?
PLEASE DESCRIBE THE TRAUMA AND THE DATE IT OCCURRED

Y N HAS YOUR CHILD EVER FALLEN FROM STAIRS?

Y N HAS YOUR CHILD EVER BEEN IN A MOTOR VEHICLE ACCIDENT?

Y N HAS YOUR CHILD EVER HAD A BONE FRACTURE OR JOINT
DISLOCATION? _____

Y N HAS YOUR CHILD HAD ANY OTHER TRAUMA OR INJURIES?

NUTRITION

Y N DO YOU HAVE CONCERNS ABOUT YOUR CHILD'S DIET?

Y N DOES YOUR CHILD HAVE ANY FOOD ALLERGIES?

Y N DOES YOUR CHILD TAKE VITAMIN SUPPLEMENTS?

Y N WAS YOUR CHILD BREAST FED? HOW LONG? _____

HOW OFTEN DOES YOUR CHILD EAT FAST FOOD? _____

HOW OFTEN DOES YOUR CHILD DRINK SOFT DRINKS? _____

WHAT TYPE OF SNACKS DOES YOUR CHILD EAT? _____