WELLESLEY CHIROPRACTIC OFFICE
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# Pediatric Case History

**PLEASE PRINT CLEARLY**

| Today's Date (mm/dd/yyyy) | | | | | | |
|---|---|---|---|---|---|---|
| Patient First Name | Patient Middle Name | Patient Last Name | | | | |
| Name by which they like to be called | Parents' Names | | | | | |
| Street Address | | | | | Apt/Suite | |
| City | State | Zip/Postal Code | Country | | | |
| Mobile Phone ( ) | Home Phone ( ) | Work Phone ( ) | | | | |
| Email Address (Please give us one you check regularly) | | | | | | |
| Birth Date (mm/dd/yyyy) | Age | Sex | Height Feet | Height Inches | Weight Pounds | Weight Ounces |
| Number of siblings | Hours of sleep per night | Quality of sleep (circle one) **Good Fair Poor** | Has patient had previous chiropractic care? | | | |
| When? | Where? | | | | | |
| Why? | | | | | | |

The practice of Chiropractic is based upon the location and adjustment of subluxations. These spinal and cranial subluxations are caused by any stress to which your body cannot adapt. These stresses may be PHYSICAL, CHEMICAL or EMOTIONAL in nature.

| What is your reason for contacting our office? |
|---|
| |
| Previous treatment and therapies undergone |
| |
| Present and past medications |
| |

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## HISTORY OF CONDITION

**Date of onset:** _____/_____/_____ Sudden or gradual

**Duration:** minutes hours days weeks months years

**Pattern of problem:** constant intermittent occasional

**What starts it?** _____

**What exacerbates it?** _____

**What diminishes it?** _____

**Effects on function and daily activity:** _____

## PRENATAL HISTORY

**Duration of gestation:** _____ weeks **Was the pregnancy normal?** Yes No

**List any significant complications during the pregnancy:**

**List any medications taken during pregnancy:** _____

## BIRTH

**Place of Delivery:** Home Hospital Birthing Center Other: _____

**Was the delivery normal?** Yes No **Were drugs used during delivery?** Yes No

**List any complications of delivery:** _____

_____

_____

**List any medications taken during delivery:** _____

_____

**Were forceps used for delivery?** Yes No

**APGAR score at birth:** _____ **APGAR score at 5 minutes:** _____

**Birth weight:** _____ lb. _____ oz. **Length:** _____ inches

## DEVELOPMENTAL HISTORY

**Was the infant alert and responsive within 12 hours of the delivery?** Yes No

**At what age did your child:**

Respond to sound _____ Follow objects with eyes _____ Hold head up _____

Sit alone _____ Crawl _____ Stand _____

Walk alone _____ Talk _____

## NUTRITIONAL HISTORY

**Breastfed for:** _____ months **Age began solid food:** _____

**Formula began at age:** _____ for _____ months **Type:** _____

**Cow's milk began at age:** _____ **Other milk began** _____ **Type:** _____

**Please list any known food allergies:** _____

_____

## SOCIAL BEHAVIOR

Please describe in detail any abnormal or troublesome behavior your child displays, including but not limited to: aggressive tendencies, explosive anger, constantly withdrawing, overwhelmed easily, inability to sleep (either falling asleep or staying asleep), lack of concentration, constant daydreaming, hyperactivity, hyperirritability, bed wetting, difficulty following directions, gross or fine motor coordination, fits of crying, temper tantrums, seizure activity, stuttering, tics or twitching etc.:

## CHILDHOOD DISEASES

Chickenpox Mumps Measles German Measles Pertussis Asthma

Chronic Ear Infections Frequent Colds/Bronchitis Other: _____

## IMMUNIZATIONS

**Has your child been immunized?** Yes No

**If yes, were all recommended immunizations given?** Yes No

**Were any immunizations left out or substituted?** Yes No

**Please list:**

## FAMILY HISTORY

**List any significant family history (cancer, diabetes, heart disease, neurological disorders, metabolic disorders, etc.)**

# PLEASE READ AND SIGN THE STATEMENTS BELOW:

## AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Wellesley Chiropractic Office to administer chiropractic care to my son / daughter / ward.

Signature _____ Date _____

Relationship to patient (CIRCLE ONE): PARENT GUARDIAN

## PAYMENT AND INSURANCE INFORMATION

If your child here because she/he has been involved in an accident (automobile, personal or work-related), please notify us immediately and fill out an additional accident information form.

### PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH OUR OFFICE

I, _____ am responsible for payment and I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. I clearly understand and agree that all services rendered to me by Wellesley Chiropractic Office are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature _____ Date _____

Relationship to patient (CIRCLE ONE): PARENT GUARDIAN