Child's Case History

Date: _____ # _____

CHILD'S NAME: _____ DATE OF BIRTH: _____ AGE: _____ SEX: M F

PARENT'S NAME: _____ ADDRESS: (Street #) _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

PARENT'S EMAIL ADDRESS: _____

TEXT REMINDERS: YES___ NO___ BEFORE VISIT: 1hr 4hrs 1 day CELL PROVIDER: _____

SS#: _____ MOTHER'S WORK PHONE: _____ FATHER'S WORK PHONE _____

NAME OF EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

REFERRED TO THIS OFFICE BY: _____ (Website/Google, Friend, Dr., Etc.)

HAS CHILD RECEIVED CHIROPRACTIC CARE BEFORE? YES___ NO___ IF YES, WHEN? _____

WHERE? _____

DOES CHILD HAVE HEALTH INSURANCE? YES___ NO___ NAME OF INSURANCE: _____

PEDIATRICIAN/FAMILY MD: _____

NAME OF INSURED: _____ RELATIONSHIP: _____

MEDICARE: YES___ NO___ MEDICAID: YES___ NO___

ARE YOUR PRESENT PROBLEMS, COMPLAINTS, INJURIES DUE TO:

____ AUTO RELATED ACCIDENT/ ____ PERSONAL INJURY/ DATE OF INJURY _____

PLEASE LIST YOUR HEALTH COMPLAINT(S)/SYMPTOMS:

A _____

B _____

C _____

D _____

DR'S COMMENTS

PLEASE CIRCLE (Y) FOR <u>YES</u> or (N) FOR <u>NO</u>:

Has any doctor been consulted for the current complaints? Y N

Has child been hospitalized for the current complaints? Y N

Have there been any changes in bodily functions (urination, bowel habits, respiration, digestion, vision or other)? Y N;
If yes, explain: _____

Have you found anything that makes the problem <u>better</u>? Y N;
If yes, explain: _____

Have you found anything that makes the problem <u>worse</u> (coughing, sneezing, straining when moving your bowels, certain positions)?
Y N; If yes, explain: _____

Does condition awaken him/her from sleep? Y N Quality of Sleep: GOOD FAIR POOR

Has child missed any school? Y N; If yes, explain: _____

Have you had <u>time</u> loss from work or school? Y N; If yes, explain: _____

Was child born with a condition that may relate to this complaint? Y N; If yes, explain: _____

_____

Does child have any conditions other than those listed above? Y N;
If yes, explain: _____

Does the child take any medications? Y N; If yes, explain: _____

_____

Is there any family history of the following conditions (please circle)

Diabetes Heart Kidney Cancer Back Stroke Arthritis Other _____

Place a "**B**", if the child has experienced any of the following BEFORE, a "**N**" if the child is experiencing any NOW, or "**B&N**" if both apply.

___ Headache
___ Head Feels Heavy
___ Loss of Memory
___ Light-Headedness
___ Fainting
___ Dizziness
___ Fatigue
___ Weakness
___ Blurred Vision
___ Light Bothers Eyes
___ Loss of Consciousness
___ Loss of Smell
___ Loss of Taste
___ Loss of Balance
___ Loss of Hearing
___ Ear Problems
___ Ringing in Ears

___ Poor Vision
___ Eye Problems
___ Sinus Problems
___ Nasal Problems
___ Whooping Cough
___ Thyroid Problems
___ Throat Problems
___ Frequent Colds
___ Low Resistance
___ Nervousness
___ Tension
___ Depression
___ Convulsions/Seizures
___ Epilepsy
___ Nausea
___ Stomach Problems
___ Vomiting

___ Speech Problems
___ Allergies
___ Abnormal Weight Loss
___ Chest Pain
___ Rib Pain
___ Heart Problems
___ High Blood Pressure
___ Respiratory (Breathing) Problems
___ Asthma
___ Tuberculosis
___ Measles
___ Mumps
___ Rheumatic Fever
___ Scarlet Fever
___ Chicken Pox
___ Digestive Problems

___ Bedwetting
___ Hernias
___ Gall Bladder Problems
___ Liver Problems
___ Colon Problems
___ Constipation
___ Diarrhea
___ Kidney Problems
___ Urinary Problems
___ Tailbone Problems
___ Sacroiliac Problems
___ Poor Circulation
___ Swelling
Where?_____
___ Swollen Joint(s)
Where?_____
___ Cystic Fibrosis

___ Leg Cramping
___ Foot Cramping
___ Arthritis
___ Avascular Necrosis
___ Psoriasis
___ Muscle Degeneration
What type?_____
___ Diabetes/Insulin Dependent
___ Polio
___ Meningitis
___ AIDS
___ Hyperactivity
___ Encephalitis
___ Bone Disease
___ Walking Problems
___ Joint Problems

Pain in:
___ Arms R L
___ Hands R L
___ Knee R L
___ Legs R L
___ Feet R L
___ Hips R L

Numbness in:
___ Arms R L
___ Hands R L
___ Legs R L
___ Feet R L

Neck:
___ Pain
___ Stiffness
___ Grinding
___ Popping

Midback:
___ Pain
___ Stiffness
___ Grinding
___ Popping

Lowback:
___ Pain
___ Stiffness
___ Grinding
___ Popping

Child's Birth History:

Apgar Score: _____
Problems During Pregnancy: _____
Medication/Drugs Taken During Pregnancy or Delivery: _____
Were there any illnesses during the pregnancy? _____
Was alcohol consumed during pregnancy? Y N Did the mother smoke during pregnancy? Y N _____
Medication/Drugs Given Child After Birth: _____
Was child premature? Y N
Type of Birth: Normal Vaginal ___ Forceps ___ Breech ___ Cesarean ___
Home: _____ Birthing Center: _____ Hospital: _____
Was incubation utilized? Y N Any Infections? Y N Length of labor? _____ Any complications? _____
_____
Any vaccinations? _____ Any complications from vaccinations? Y N;
If yes, explain: _____

List any **recent** and/or **past:**

Accidents, falls, or injuries: _____
_____
Broken Bones/Dislocations: _____
Surgeries: _____
Illnesses/Diseases: _____
Specialized Tests: _____
Hospital Stays or Visits: _____
Has child been treated on an emergency basis?
Please list any additional comments you wish to make: _____
_____

It is understood and agreed that the amount paid Radix Chiropractic for x-rays is for evaluation only and the x-ray negatives will remain the property of this office.

Legal Guardian's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____