PEDIATRIC CASE HISTORY

Pt #: _____

Foundation Chiropractic Center

895 State Farm Road Suite 401 Boone,NC 28607 828-865-6500

Child/Patient's Name: _____ Date: _____
Date of Birth: _____ Age: _____ Sex: Male Female
Address: _____ City: _____ State: _____ Zip: _____
Mother's Name: _____ Father's Name: _____
Phone (Home): _____ Cell: _____ Work: _____
E-mail: _____
Referred by: _____ How did you hear about us? _____

Present complaint: _____
Pain/problem started on: _____ Have they experienced this before? **Y N** When? _____
How did the symptoms begin? (i.e. gradually, suddenly, etc.) _____
Is this due to an injury or accident? **Y N** Describe _____
Frequency of symptoms: ____ Daily ____ 2-3 times weekly ____ Sporadic Describe _____
Pains are: ____ Sharp ____ Dull/Ache ____ Numbness ____ Shooting ____ Burning ____ Tingling
Symptoms are better with: _____ Symptoms are worse with: _____
How are the symptoms changing? ____ Getting better ____ Not changing ____ Getting worse
Is this condition worse at certain parts of the day? ____ Morning ____ Afternoon ____ Evening ____ During sleep
Are you currently or have you seen a doctor or chiropractor for this condition? **Y N**
Dr./Office name: _____ When? _____ What were the results? _____

Birth Weight: _____ Birth Length: _____ Current Weight: _____ Current Height: _____
Type of birth: ____ Vaginal ____ Forceps ____ Breech ____ Cesarean ____ Home ____ Birthing Center ____ Hospital
Problems during pregnancy: _____
Problems during labor/delivery: _____
Infant feeding: _____ Breast _____ Bottle _____ Formula
Immunization history: _____ Up-to-date _____ Reduced schedule _____ None
Current hours of sleep per night: _____ Quality of sleep: _____ Good _____ Fair _____ Poor
Obstetrician / Midwife: Name: _____ Location: _____
Pediatrician / Family MD: Name: _____ Location: _____
Date of last visit to MD: _____ Purpose: _____
Has your child ever been treated on an emergency basis? **Y N** Describe: _____
_____
Please list any past and present health conditions: _____
_____
Please list any family health conditions: _____
_____
Please list and describe any operations and/or procedures: _____
_____
Please list any over-the-counter and prescription medications currently taking: _____
_____

PLEASE MARK AN (X) IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING IN THE PAST YEAR:

General
_____ Fatigue
_____ Fever
_____ Weight gain
_____ Weight loss

HEENT
_____ Runny nose
_____ Stuffy nose
_____ Sneezing
_____ Ear pulling
_____ Itchy / red eyes
_____ Drooling
_____ Sore throat
_____ Hearing loss
_____ Allergies

Musculoskeletal
_____ Decreased range of motion
_____ Joint pain
_____ Joint redness
_____ Joint swelling
_____ Joint stiffness
_____ Muscle weakness
_____ Muscle aches / pains

Over

Neurological

_____ Loss of bowel / bladder control
_____ Dizziness / vertigo
_____ Headaches
_____ Numbness / tingling
_____ Passing out
_____ Seizures
_____ Tremor

Psychiatric

_____ Anxiety
_____ Change in sleep pattern
_____ Depression
_____ Hallucinations
_____ Suicidal thoughts
_____ ADD / ADHD
_____ Autism

Cardiovascular

_____ Chest pain
_____ Leg swelling
_____ Palpitations
_____ Irregular

Respiratory

_____ Chronic cough
_____ Difficulty breathing
_____ Coughing up blood
_____ Sputum production
_____ Wheezing
_____ Asthma

Other

_____ Constipation
_____ Diarrhea
_____ Nausea
_____ Urinary problems / bedwetting
_____ Skin problems

Patient's/Guardian's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____