CHILD CASE HISTORY

ABOUT THE CHILD

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Age _____ Sex M F

Parent(s) Name(s) _____ Home phone _____

Cell Phone _____ E-mail _____

Name of child's other healthcare provider(s) _____

REASON FOR THIS VISIT

What is the reason for your child's visit? _____

_____

When did this condition begin? _____ Has this condition ☐ gotten worse ☐ stayed constant ☐ comes and goes

Is the purpose of this visit related to any of the following?
☐ sports ☐ auto accident ☐ fall ☐ home injury ☐ chronic discomfort ☐ other _____

Have you seen other doctors for this condition? ☐ Yes ☐ No
Doctor's Name(s) _____ Types of Treatment _____
Results of Treatment _____

CHILD HEALTH HISTORY

Has your child experienced any of the following?
☐allergies ☐asthma ☐attention problems ☐breathing problems ☐car accident ☐severe fall ☐broken bone ☐colic ☐constipation ☐bed wetting ☐hyperactivity ☐ear problems ☐pink eye ☐frequent colds/cough ☐digestive problems ☐vision problems ☐headaches ☐difficulty sleeping ☐irritability ☐skin problems ☐ hospitalization/surgery ☐other
Explain any checked: _____
Does your child have any developmental issues/concerns? _____

MOTHER'S PREGNANCY & LABOR

During the pregnancy, did the mother:

- ☐ Experience any illness? List _____
- ☐ Take medications? List _____
- ☐ Smoke or consume alcohol or drugs? List _____
- ☐ Undergo excessive stress? Reason _____
- ☐ Have any complications? List _____

BIRTHING PROCESS

Birthplace: ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other _____
Type of birth: ☐ Vaginal ☐ C-section ☐ Cephalic (head first) ☐ Breech (feet first)
Birth Assistants: ☐ Obstetrician ☐ Midwife ☐ Doula
Was labor chemically induced? Yes ☐ No ☐
Procedures: ☐ Forceps ☐ Vacuum Extraction ☐ Epidural ☐ Episiotomy ☐ Pulling/Twisting of Baby
How long did labor and delivery last? _____
Any complications? _____
Gestational age of child (how many weeks) at birth: _____ Birth weight: _____

Check any of the following if the child experienced it immediately after birth:
☐ Jaundice ☐ Feeding Problems ☐ Respiratory Problems ☐ Displaced or Broken Joints
☐ Other Conditions (s) _____

VACCINATIONS

Is your child vaccinated: Yes ☐ No ☐

If yes, check vaccinations received: ☐ DTP or Tdap/ DTap ☐ MMR ☐ Polio ☐ Chicken Pox ☐ Hepatitis ☐ Flu ☐ Other _____

Any reactions to the vaccine: _____

Was your child breastfed? Yes ☐ No ☐ If yes, for how long? _____

CHILD'S CURRENT HEALTH STATUS

Is your child accident prone? Yes ☐ No ☐

Has your child ever: ☐ been hospitalized ☐ had a severe fall ☐ been in a car accident ☐ taken antibiotics

Explain any checked answers _____

Does your child **CURRENTLY** take any medications and/or supplements? Is Yes, please list:

_____

Does your child have difficulty interaction with schoolmates or friends? ☐ Yes ☐ No

Have you or anyone else noticed that your child in nervous, twitches, shakes, or exhibits 'rocking' behavior? ☐ Yes ☐ No

What changes (if any) in your child's health or behavior would you like accomplished?

_____

_____

GOALS FOR MY CHILD'S CARE

Children see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your child's Chiropractic care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ RELIEF CARE – Symptomatic relief of pain or discomfort

☐ CORRECTIVE CARE – Correcting and relieving the cause of the problem as well as the symptoms

☐ COMPREHENSIVE CARE – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

☐ I want the Doctor to select the type of care appropriate for my child

_____ _____

Signature of Parent/Guardian Date

CONSENT

I, the undersigned, parent/person having legal custody/guardianship of _____ a minor, do hereby authorize Dr. Cassandra Shum, as agent for the undersigned to consent to any X-ray examination and chiropractic evaluation or care of my child.

_____ _____

Signature of Parent/Guardian Date