PEDIATRIC CASE HISTORY FORM

Name of Parent/Guardian:_____ Date of Birth:_____ Phone #:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Whom may we thank for referring you to our office? _____

Child's Full Name:_____ Gender: M / F Date of Birth:_____ Age:_____

Birth Length:_____ Birth Weight:_____ Current Length: _____ Current Weight: _____

Type of Birth: Normal Vaginal Forceps Extraction Breech Cesarean Scheduled Caesarean Emergency

Place of Birth: Hospital Home Birthing Center: _____

Problems during pregnancy: _____

Problems during labor/ delivery: _____

APGAR Scores: _____ /_____ Was the baby at birth: Jaundice (Yellow) Cyanosis (Blue)

Type of feeding: Breast Bottle (Breast Milk) Bottle (Formula) _____

Quality of sleep: Good Fair Poor Hours of sleep per night: _____

Prescribed medications: _____

Any medical conditions or syndromes: _____

Any history of surgeries: _____

Obstetrician / Midwife Name:_____ Date of last visit: _____

Pediatrician Name: _____ Date of last visit: _____

Reason for this appointment: _____

Has your baby ever received chiropractic care? Yes / No If so, When was your last visit? _____

Were you satisfied with the care you received? Yes / No How could it have been better? _____

MEDICAL HISTORY

Please circle the following conditions your child may have had in the past or have now:

Allergies	Constipation	Headaches	Mumps	Rubella
Anemia	Convulsions	Heart Problems	Muscle Jerking	Scoliosis
Arm / Leg Problems	Diabetes	Heart Disease	Neck Pain	Sinus Trouble
Arthritis	Diarrhea	Hyperactivity	Nervousness	Stroke
Asthma	Digestive Disorder	High Blood Pressure	Neuritis	Thyroid Problems
Backaches	Ear Infections	Irregular Periods	Pleurisy	Tuberculosis
Bed Wetting	Epilepsy	Kidney Disease	Pneumonia	Ulcers
Behavioral Problems	Fainting	Low Blood Sugar	Polio	Uterine Cyst/Tumors
Broken Bones	Flat Feet	Measles	Poor Appetite	Difficulty Walking
Chronic Earaches	Gall Bladder Disease	Menstrual Cramps	Rheumatic Fever	Whooping Cough
Colds / Flu	"Growing Pains"	Migraines	Rosella	Other_____

MEDICATIONS/VITAMINS/HERBS
Please list any medications your child is currently taking

_____
_____
_____

ALLERGIES
Please list any known allergies you are aware of

_____
_____
_____

HEALTH HISTORY

Please identify all facilities and providers your child seen for these or any other conditions in the past or present.

Dr Name or Facility	Condition/Problem	Treatment Received	From When to When

Injuries/Surgeries for your child: (Please give description and approximate date)

	Description	**Date**
Motor Vehicle Accidents:	_____	_____
Any Falls:	_____	_____
Head Injuries:	_____	_____
Broken Bones/Dislocations:	_____	_____
Surgeries:	_____	_____
Other Serious Injuries:	_____	_____

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

The above information is accurate and complete to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's medical status. I will not hold Dr. Kevin Smith or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I authorize Dr. Kevin Smith to release any information including the diagnosis and the records of any treatment or examination rendered to me to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Trinity Family Chiropractic, PC all insurance benefits otherwise payable to me.

PRINT NAME _____SIGNATURE_____DATE_____