Abundant Life Chiropractic

Office #_____
Date _____

CONFIDENTIAL PEDIATRIC CASE HISTORY

Child's Name _____
Mothers Name_____ Father's Name_____
Address_____ City_____ St._____ Zip_____
Home Phone_____Mother'sWork_____FathersWork_____

Birth Date _____ Age____ Birth Weight _____ Current Weight_____ Sex: M Or F
No. Of Siblings_____ Birth Length_____ Current Height_____

Type Of Birth: Normal Vaginal____ Forceps ____ Breech____ Cesarean_____
Location: Home_____ Birthing Center_____ Hospital _____
Problems During Pregnancy:_____
Problems During Labor/Delivery_____
Apgar Scores____ ____Was There Presence At Birth Of The Following?
_____Jaundice (Yellow)_____Cyanosis (Blue)
Congenital Anomalies / Defects _____

Infant Feeding: Breast_____ Bottle _____ Formula _____
No. Of Hours Sleep Per Night_____ Quality Of Sleep Good_____ Fair_____ Poor_____

Obstetrician / Midwife _____ Located_____
Pediatrician / Family MD_____ Located_____
Date Of Last Visit To MD_____ Purpose_____
Immunization History_____
Purpose of this appointment:_____
Has your child ever been treated on an emergency basis?_____
If yes, please explain_____

Delivery/BirthHistory_____

At what age did the child:
Respond to sound____ Follow an object with his/her eyes____ Hold head up_____
Sit alone_____ Crawl_____ Stand_____ Walk alone_____
At what age, if ever, did this child suffer from the following childhood diseases?
ChickenPox_____Mumps_____Measles_____Rubella_____
Rubeola _____ Whooping Cough_____ Other_____

Has this child ever suffered from: (Please circle the following that apply)

Headaches	Orthopedic Problems	Digestive Disorders	Behavioral Problems
Dizziness	Neck Problems	Poor Appetite	ADD/ADHD
Fainting	Arm Problems	Stomach Aches	Ruptures/Hernia
Seizures/Convulsions	Leg Problems	Reflux	Muscle Pain
Heart Trouble	Joint Problems	Constipation	Growing Pains
Chronic Earaches	Backaches	Diarrhea	Allergies to_____
Sinus Trouble	Poor Posture	Diabetes	Allergies to_____
Asthma	Scoliosis	Hypertension	Allergies to_____
Colds/Flu	Walking Trouble	Anemia	Other_____
Colic	Broken Bones	Bed Wetting	Other_____

Has this child ever suffered from the following spinal traumas?

Fall in baby walker	Fall from bed or couch	Fall off skateboard or skates
Fall from crib	Fall off swing	Fall off bicycle
Fall from highchair	Fall off slide	Fall down stairs
Fall from changing table	Fall off monkey bars	Other:_____

Has this child ever sustained an injury playing organized sports? ____ If yes, please explain:
_____

Has this child ever sustained injuries in an auto accident? ____ If yes, please explain:
_____

Present History:
_____
_____
_____.

Surgery: _____

Medications: _____

Accidents: _____

Family History: _____