CONFIDENTIAL PATIENT CASE HISTORY
PEDIATRIC (AGE 5 – 15 YEARS OLD)

Dear Parent:
Please complete this questionnaire. Your answers will help us determine if chiropractic can help your child. If we do not sincerely believe your child's condition will respond satisfactorily, we will not accept your child's case. THANK YOU.

Child's Name _____ Social Security # _____

Age_____ DOB _____ Delivery: □ Vaginal □ Forceps □ Vacuum Extraction □ C-Section

Address _____ City _____ State_____ Zip Code _____

Parent's Information: Name_____ Home # _____

Work # _____ Cell # _____ Referred by _____

Nearest Relative and Telephone: _____

HEALTH INFORMATION:

Is your child here for: □ Wellness Checkup □ Specific Complaint
Please explain: _____
How long has your child had this condition? _____ has your child had this condition in the past? Y N
Which activities aggravate your child's condition? _____
Is their condition getting progressively worse? □ YES □ NO
Is their condition interfering with their: □ SCHOOL □ SLEEP □ DAILY ROUTINE □ OTHER
Name of Pediatrician: _____
Other doctors who treated this condition: _____
List surgical operations and years: _____
Medications your child now takes: □ over the counter Pain/Fever Reducer □ Allergy Medicine
□ Vitamins □ Others _____
Has your child suffered from: □ Colic □ Ear Infection □ Recurrent Cold □ Chronic Cough □ Asthma
Does your child wet the bed? □ YES □ NO ~ Do you feel your child is sick quite often? □ YES □ NO
Has your child been in an auto accident, even a minor "fender – bender"? □YES □ NO
If yes, Describe: _____
Has your child had any other personal injuries or accidents? □ YES □ NO
If yes, Describe: _____

INSURANCE INFORMATION: Name of Insurance: _____

Insured's Name: _____ Insured DOB: _____ Insured SSN # _____

AUTHORIZATION OF CARE OF A MINOR:

I hereby authorize this office and its doctor to administer care as they deem necessary to my son / daughter / ward (upon approval of parent or guardian).

Signed: _____ Date: _____

Parent/Guardian Printed Name: _____Home #:_____