# Pediatric Case History

(Under 18 years of age)

Dr. Janet McGaurn
Family Chiropractor

Referred by_____

Child's Name_____ Date of Birth _____ Sex: ❑ M ❑ F

Address _____
STREET CITY STATE ZIP

Parents' Names _____

Phone (home)_____ (work)_____ (cell) _____

Email _____

The human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. The healthy function of every cell, every system, every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system.

From the birth process until the present, events have occurred in your child's life which may have caused interference and damage to this delicate system. Physical, emotional and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex.

This form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of your child's nervous system and therefore impair your child's inborn health potential.

***We are here for you and your family and we encourage you to ask questions.***
***Your participation is vital and will help determine your child's care and results.***

## ASSESSMENT

1. Purpose for contacting us? _____

   Other doctors seen for this condition? ❑ Yes ❑ No

   Doctors' Names and Prior Treatment _____

   _____

2. Check any of the following conditions your child has suffered from during the past six months:

| | | | |
|---|---|---|---|
| ❑ Ear Infections | ❑ Scoliosis | ❑ Seizures | ❑ Chronic Colds |
| ❑ Headaches | ❑ Asthma/Allergies | ❑ Digestive Problems | ❑ ADD or ADHD |
| ❑ Recurring Fevers | ❑ Growing Pains or Back Pain | ❑ Colic | ❑ Bed wetting |
| ❑ Car Accident | ❑ Temper Tantrums | ❑ Other_____ | |

3. Check any of the following childhood diseases your child has had:

| | | |
|---|---|---|
| ❑ Chicken Pox Age_____ | ❑ Rubella Age_____ | ❑ Rubeola Age_____ |
| ❑ Mumps Age_____ | ❑ Whooping Cough Age_____ | ❑ Other Age_____ |

4. What vaccinations has your child received?_____

   Did your child experience any behavioral, emotional or physical changes after any vaccination? ❑ Yes ❑ No

   Describe _____

   _____

5. Place of birth: ❑ Home ❑ Birthing Center ❑ Hospital

   Name of Obstetrician/Midwife _____

   Complications during pregnancy? ❑ Yes ❑ No List _____

   Did you have an ultrasound during this pregnancy? ❑ Yes ❑ No How many? _____

   Was labor induced? ❑ Yes ❑ No

   Birth Intervention: ❑ Forceps ❑ Vacuum Extraction ❑ C-section: _____Emergency or _____Planned

   Complications during delivery? ❑ Yes ❑ No List _____

   Genetic Disorders or Disabilities? ❑ Yes ❑ No List _____

   Birth Weight_____ Birth Length_____ APGAR scores_____

6. Did you breastfeed your child? ❑ Yes ❑ No How long_____

   Did you use Formula? ❑ Yes ❑ No How long _____Type _____

   Introduction to solids at _____months. Introduction to cow's milk at _____months

   Food/Juice Allergies or Intolerances? ❑ Yes ❑ No List _____

7. According to the National Safety Council approximately 50% of infants have fallen onto their heads during their first years of life. Another study reveals 1/4 million children are injured in playground activities annually.

   Can you recall any such jolts, falls or traumas to your child? ❑ Yes ❑ No Type_____

8. Is/has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ❑ Yes ❑ No List_____

9. During the following developmental times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation. At approximately what age was your child able to:

   Respond to sound _____ Cross crawl _____ Stand alone _____

   Respond to visual stimuli _____ Sit up _____ Walk alone _____

   Hold head up _____

10. Name of Pediatrician_____

    Date of last visit_____ / _____ / _____ Reason _____

    Number of doses of antibiotics your child has taken: During the past 6 months_____ Total during lifetime _____

    Other prescription medications your child has taken: _____

    Has your child had any previous surgery or emergency room visits? List _____

    _____

11. Previous Chiropractic Care? ❑ Yes ❑ No Name of Chiropractor _____

    Date of last visit_____ / _____ / _____ Reason _____

## AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company _____ Policy # _____

Parent's signature_____ Date _____