Chart Number : ____________

Case History Intake Form – Child / Infant

Full Name : ____ Date of Birth : ________________
(Last) (Middle) (First)

CURRENT SYMPTOMS

The symptoms that prompted you to seek care today include:____

____

And are a result of? ☐ Fall ☐ Car Accident ☐ Birth / Delivery ☐ Sports / Activity ☐ Other : ______________________

Choose the level of discomfort (circle): *No Pain* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Worst pain ever*

When did they start feeling this pain: ______________________________ Hour: ________ ☐ A.M. ☐ P.M.

How often does your child feel/complain about it? ☐ Constant ☐ Only once ☐ Comes and Goes ☐ Other : ____________

What other health care has your child received for this problem? ______________________________________

Does your child have any consistent postural behaviors ie: Always rests head on left or right side? ______________

____

What are your child's regular sleeping habits? ☐ 0-4hrs/night ☐ 4-8 hrs/night ☐ 8+ hrs/night ☐ Other ____________

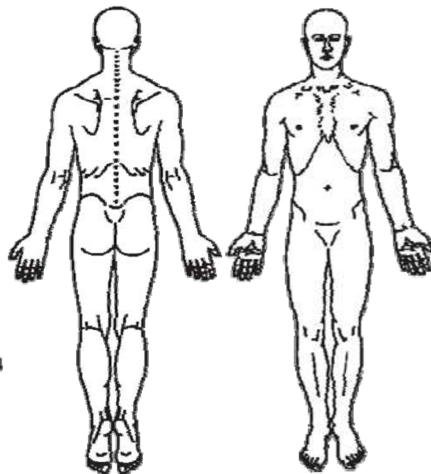
Childhood Symptoms:

(Tick all that apply)

☐ Allergies
☐ Appetite Issues
☐ Asthma
☐ Bed Wetting
☐ Colic / Constipation
☐ Ear Infections
☐ Headaches
☐ Hyperactivity
☐ Leg Cramps
☐ Scoliosis
☐ Fractures
☐ Dislocations
☐ Other: ____

Location (where does it hurt)

Circle areas on diagram



Radiating (does the pain travel to other parts of the body?)

☐ Head ☐ Neck ☐ Arms ☐ Hands ☐ Legs ☐ Feet

Aggravating / Relieving (Time of day or activities)

What makes it worse ____________________

What makes it better ____________________

Prior interventions (what have you done for relief)

☐ Over the counter drugs ☐ Prescription Meds
☐ Heat ☐ Ice ☐ Chiropractic ☐ Massage Therapy
☐ Physiotherapy ☐ Acupuncture ☐ Surgery
☐ Other: ______________________________

How does the current condition interfere with:

Sleep Patterns: ____

Mobility – crawl / walk / stand: ____

Speech Patterns: ____

Behavior Issues: ____

(Continue on next page)

Chart Number : ______________

PREGNANCY / DELIVERY

Pregnancy time: ☐ Full-term ☐ Premature ☐ Overdue? How long were you in labor for? ________________________

Did you receive an epidural? ☐ Yes ☐ No Were there any complications? ______________________________________

Was the delivery ☐ Natural ☐ Homebirth ☐ Cesarean ☐ Assisted ☐ Midwife? Complications? ____________________

Are you ☐ Breastfeeding ☐ Bottle feeding ☐ Supplementing Complications? ______________________________________

Birth Weight: ________________________________ Birth Length: _________________________________

TREATMENT HISTORY

Have they ever had chiropractic treatment before? ☐ Yes ☐ No When was the last? _____________________

Have they seen another chiropractor this year? ☐ Yes ☐ No How many times? ________________________________

Have they seen any of the following this year? ☐ Massage ☐ Physio ☐ Naturopath ☐ Acupuncturist Total # of visits : ________

Recent X-rays? ☐ Yes ☐ No If yes, please tell the front desk for X-Ray authorization form.

LIFESTYLE

How active is your child? (Circle): *Not active* 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 *Very Active*

Siblings: ☐ Yes ☐ No If yes, how many? _______ Brothers ________ Sisters

What vitamins does your child currently take? ___________________________________

How much water do they drink in a day? _________________________________

How many caffeinated beverages do they consume daily? _________________

Do they wear orthotics in their shoes? ☐ Yes ☐ No If yes, how old? _______

I confirm, to the best of my knowledge, the information provided above is complete.

Signed : ____ Dated : ______________________________

Relationship to patient: ________________________________