Bosquez Chiropractic and Wellness Center

remove obstacles - restore function - improve performance - maximize potential

Pediatric Case History

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

center id	date

1 PATIENT INFORMATION

last name	first name	m.i.

2 HEALTH COMPLAINTS

What is your reason for seeking us?

How long has your child been experiencing these symptoms?

Are the symptoms getting: □ Better □ Worse

Other Doctors seen for this condition: □ No □ Yes

If yes, please list name and prior treatment

Other Health Problems?

Check any of the following conditions your child has suffered from: (check all that apply)

□ Ear Infections	□ Scoliosis	□ Seizures	□ Chronic Colds	□ Growing Pains
□ Asthma/Allergies	□ Digestive Problems	□ ADHD	□ Recurring Fevers	□ Other:
□ Colic	□ Bed Wetting	□ Car Accident	□ Temper Tantrums	
□ Behavioral Problems	□ Constipation	□ Diarrhea	□ Digestive Disorders	

Previous Chiropractic care: □ No □ Yes Chiropractor Name:

Date of last visit: Reason:

Name of Pediatrician:

Date of last visit: Reason:

Are you satisfied with the care your child has received there? □ No □ Yes

3 PRENATAL HISTORY

Name of Obstetrician / Midwife:

Complications during pregnancy? □ No □ Yes List:

Ultrasounds during pregnancy? □ No □ Yes Number:

Medications during pregnancy

	medication	reason		medication	reason
1			3		
2			4		

Cigarette / Alcohol use during pregnancy? □ No □ Yes

Location of birth: □ Hospital □ Birthing Center □ Home

Birth Intervention: □ Forceps □ Vacuum Extraction □ Caesarian Section: Emergency or Planned

Complications during delivery? □ No □ Yes List:

Genetic Disorders or Disabilities? □ No □ Yes List:

Birth Weight: Birth Length: APGAR Scores:

4 FEEDING HISTORY

Breast Fed □ No □ Yes How Long:

Formula Fed □ No □ Yes How Long: Type:

Introduced to solids at: months Cow's Milk at: months

Food / Juice Allergies or Intolerance: □ No □ Yes List:

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5 DEVELOPMENTAL HISTORY

During the following 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 (spinal nerve interference).

At what age was your child able to:

Respond to Sound:	Cross Crawl:
Respond to Visual Stimuli:	Stand Alone:
Hold Head up:	Walk Alone:
Sit Up:	

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.) Was this the case with your child?

Was this the case with your child? □ No □ Yes

Is / Has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)?

□ No □ Yes List:

Has your child ever been involved in a car accident?	□ No	□ Yes	
Has your child ever been seen on an emergency basis?	□ No	□ Yes	
Other traumas not described above?	□ No	□ Yes	List:
Prior surgery?	□ No	□ Yes	List:
Menstruation	□ No	□ Yes	Age:

6 CHILDHOOD DISEASES

Chicken Pox:	□ No	□ Yes	Age:	Mumps:	□ No	□ Yes	Age:
Rubella:	□ No	□ Yes	Age:	Rubeola:	□ No	□ Yes	Age:
Whooping Cough:	□ No	□ Yes	Age:	Other:	□ No	□ Yes	Age:

7 MEDICATIONS

List any medications your child is currently taking

	medication	reason		medication	reason
1			3		
2			4		

Vaccination history:

Number of doses of **Antibiotics** your child has taken:

During the past six months: Total during his/her lifetime:

Number of **Other Prescription Medications** your child has taken:

During the past six months: Total during his/her lifetime:

List any nutritional supplements your child is currently taking.

	supplement	reason		supplement	reason
1			3		
2			4		

8 AUTHORIZATION

I hereby request and authorize the doctors and staff of Bosquez Chiropractic and Wellness Center to perform diagnositc tests and render care to my Son / Daughter. This authorization is intended to include radiographic examination at the doctors' discretion. As of the date stated below, I have legal right to select and authorize health care services for the patient named above. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify Bosquez Chiropractic and Wellness Center.

Guardian's Signature: Date:

Guardian's Name, Printed:

Guardian's Relationship to patient: