Crestview Family Chiropractic

CONFIDENTIAL CASE HISTORY

Your answers will help us determine if our care can help you. If we do not believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

DATE:

PERSONAL INFORMATION

Child's Name: _____ **PARENT'S Email** _____

Address: _____ City: _____
Postal Code: _____ DoB: yy_____mm____dd____ Age: _____ Gender: ❑ Male ❑ Female
Parent/Guardian: _____ Cell: _____ Work: _____ Home: _____
Parent/Guardian: _____ Cell: _____ Work: _____ Home: _____
Who has custody of the child for medical decisions? _____
Family Physician's Name, Address, Phone: _____
Sibling Names & Ages: _____

Who referred you to our office? _____

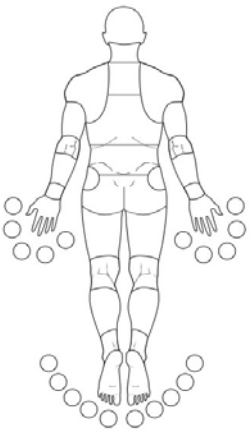
PREVIOUS HEALTH CARE INFORMATION

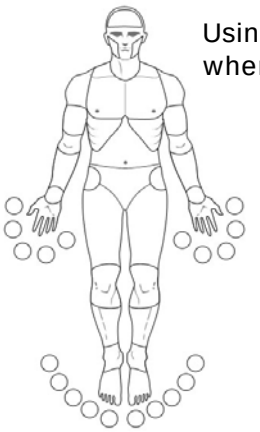
Have you consulted a chiropractor previously? ❑No ❑Yes, Doctor's Name: _____
When was your last visit? _____ What was the problem? _____
Were x-rays taken? ❑Yes ❑No Was the experience a good one? ❑Yes ❑No

REASON FOR CONSULTING OUR OFFICE

What is your primary health concern today? _____
How long have you been suffering from this? _____
How often are you experiencing this problem? (daily, weekly, monthly) _____
Which part of the day do you feel your symptoms are at their worst? (morning, afternoon, evening, at night)
What kinds of activities aggravate your symptoms? _____
Describe the activities that tend to help. _____
How would you describe your pain? (throbbing, ache, tingling, shooting, hot/cold, dull, heavy) _____
Have you seen a physician for this problem? What was the diagnosis? _____
Are you taking any prescription or over-the-counter medication? Nutritional supplements? _____

How severe is your pain? 1(very light) 2 3 4 5 6 7 8 9 10(extreme)





Using a pen, carefully show us where your symptoms are.

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Tell us about the birth of your child: ❑C-section ❑Normal Vaginal
Was the delivery complicated or unusually long? ❑No ❑Yes: _____
Interventions during birth: ❑Medically induced ❑Artificial rupture of membranes ❑Vacuum ❑Forceps ❑None

Nutritional History: Breast fed? ❑No ❑Yes How long?_____ Introduced to solid food at what age?_____
Drinks cows milk? ❑Yes ❑No Food/juice allergies or sensitivities? ❑No ❑Yes: _____

How Much / How Often
▼

Aspartame (NutraSweet) _____
Sucralose (Splenda) _____
Soda _____
Dairy _____

Physical Habits / Traumas: Sleeps on: ❑Side ❑Back ❑Stomach ❑"All over the place" ❑Snores ❑Sleep apnea

According to the National Safety Council, approximately 50% of children fall head-first from a high place during their first year of life (change table, off the bed, down the stairs). Is this the case with your child? ❑No ❑Yes

Please list contact sports your child has been involved with (soccer, football, gymnastics, basketball, cheerleading, martial arts, etc). _____
Car Accidents? ❑No ❑Yes: _____
Emergency room admissions? ❑No ❑Yes: _____
Prior surgeries? ❑No ❑Yes: _____

Other Health Conditions:

❑Ear Infections	❑Scoliosis	❑Seizures	❑Chronic colds	❑Headaches
❑Asthma/Allergies	❑Digestive Problems	❑ADHD	❑Fevers	❑Growing Pains
❑Infantile Colic	❑Bed Wetting	❑Temper tantrums	Other: _____	

I hereby consent to a consultation and initial examination which may include x-rays. I certify that the information I have provided is true and complete.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____