West Michigan Chiropractic Clinic, P.L.C.

Pediatric Case History

Today's Date: _____

Patient Name: _____
First MI Last

D.O.B.: _____ **Sex: M F Age**: _____ How were you referred to our office: _____

Patient's Parents/Guardians: _____ Phone (hm): _____ (wk): _____

Address: _____ City: _____ State: _____Zip: _____
Who is responsible for this account? _____ Is the child covered by any health insurance? Yes / No
Please have a West Michigan Chiropractic team member make a copy of any insurance cards or information. Thank you.

Is this a wellness check-up or is there a health problem? _____ If there is a health problem, please describe and include any specific symptoms: _____
_____

Check any of the following conditions your child has ever had and list how many occurrences per day, wk, mo, or yr

	# Times		# Times		# Times
__ ear infections	_____	__ chronic colds	_____	__ recurring fevers	_____
__ asthma attacks	_____	__ digestive problems	_____	__ growing pains	_____
__ colic	_____	__ bed wetting	_____	__ headaches	_____
__ headaches	_____	__ seizures	_____	__ allergies _____	_____
__ car accident	_____	__ ADHD		__ scoliosis	
__ back pain	_____	__ croup/cough	_____	__ difficulty sleeping	_____

Are there any other conditions your child has that are not listed here? _____
_____

Yes / No Are there any health problems with anyone at home? Please describe: _____

Yes / No Is your child on any prescription or over the counter medications? Please list: _____
_____

If so, how often has the child been given these? (once or multiple times a day, week, month, or year) _____

Were there any complications in the birth process? (caesarean, forceps, vacuum extraction, induction of labor, anesthesia, epidural, etc.) Please describe: _____

Yes / No Has your child received any vaccinations?

Yes / No Any adverse reactions noticed upon receiving? If yes, please describe? (fever, restlessness, irritable, etc.)
_____

Yes / No Has your child been developing normally? If not, please describe: _____

Yes / No Has your child ever fallen from ANY height? Please describe: _____

Yes / No Has your child ever been involved in any kind of accident? (at the playground, daycare, bicycle, sports, auto accident, etc.) _____

Are there any other concerns that you may have regarding your child's condition, development, or care that we can be of assistance? _____
_____