Pediatric case history

Date:_____ #: _____

Name:_____ Date of birth : _____ /_____ /_____

D M Y

Address: _____

City:_____Postal Code: _____

☎ Home: _____ ☎Work : _____

Father's name: _____Address : _____

Mother's name: _____Address : _____

Referred by : _____

Reasons of consultation: _____

When did the problem start?_____

Frequency : _____

Have he been treated for this condition : ☐ Yes ☐ No If yes, when_____

By whom _____

Describe your child health since birth (Cold, ear infections, good, excellent etc.) :

_____

_____

_____

_____

His your child taking medication: ☐ Yes ☐ No, If yes, which one:

_____

_____

How many brothers or sisters ?_____

How is their Health ?

_____

_____

_____

Do you remember any falls or physical trauma ☐ Yes ☐ No

Yes, precise:

_____

_____

Describe your child birth: (long, short, easy, hard, caesarian, forceps, etc.)

_____

_____

Family doctor : _____

Has he consulted a chiropractor before : ☐ Yes ☐ No, Yes,

Who_____ When_____

_____ _____

Signature of parent Date