180° Chiropractic

Child's Case History

Please Print

Patient Information

Child's Name _____ Date of Birth _____

Mother's Name _____ Father's Name _____

Address _____ City _____ State _____ Zip Code _____

Home phone: _____ Mobile Phone: _____

Mother's History

Tell me about your prenatal time:

a. Did you exercise? ○ **Y** ○ **N** Please explain: _____

b. Did you drink alcohol? ○ **Y** ○ **N** Please explain: _____

c. Did you take drugs? ○ **Y** ○ **N** Please explain: _____

d. Did you eat regularly? ○ **Y** ○ **N** Please explain: _____

e. Did you have any spinal pain or problems during your pregnancy?
○ **Y** ○ **N** Please explain: _____

Labor:

a. How long was your labor? _____

b. Was labor artificially induced? ○ **Y** ○ **N**

c. Would you say it was: ○ Easy ○ Hard ○ Very Hard

d. Did you have a sinal block? ○ **Y** ○ **N**

e. How did you deliver the child?
○ On back ○ On all fours ○ Squatting ○ Sitting up in a birthing chair ○ Other _____

f. Did the doctor grasp/pull on child's head? ○ **Y** ○ **N**
Did you notice if the doctor twisted? ○ **Y** ○ **N**
Were forceps used? ○ **Y** ○ **N**

g. Do you remember the APGAR score? ○ **Y** ○ **N**
If so, what was it? _____

h. Any complications? _____

Baby's History

Was this child breastfed? ○ **Y** ○ **N** How long? _____

Did this child have any unusual or strange habits or behaviours as a newborn? _____

a. Colic? ○ **Y** ○ **N**

b. Fussy? ○ **Y** ○ **N** c. Alert? ○ **Y** ○ **N** d. Happy? ○ **Y** ○ **N**

e. Did child have shots (immunizations)? ○ **Y** ○ **N**

f. Did child crawl? ○ **Y** ○ **N** Beginning at what age? _____ months

g. Was child in a walker? ○ **Y** ○ **N** How long? _____

h. For how long did the child crawl? _____

i. At what age did child begin to walk? _____

j. Did you notice anything unusual about he childs efforts to learn to walk? ○ **Y** ○ **N**
Did the child fall a lot? ○ **Y** ○ **N**
Were there any particularly hard falls that you recall? ○ **Y** ○ **N**
If so, please explain: _____

Young Child

a. Ear infections? ○ **Y** ○ **N**

b. Colds? ○ **Y** ○ **N**

c. Mucus/Sinus trouble? ○ **Y** ○ **N**

d. Falls? ○ **Y** ○ **N**

e. Collisions (Automobile)? ○ **Y** ○ **N**

Anything else you have noticed about your child that you think is unusual: _____

List any medications, past or present: _____

Any diagnosed diseases: _____

Signature of Mother, Father, or Legal Guardian _____ Date _____