

Welcome to Express Your Health

Children's Case History

Child's Name _____ Birthdate _____ Sex _____

Social Security # _____ Home Phone # _____

Address _____ City _____ Zip _____

Father's Name _____ Birthdate _____

Social Security # _____ Work # _____

Mother's Name _____ Birthdate _____

Social Security # _____ Work # _____

Insurance Company _____ ID# _____

Siblings and ages _____

Who referred you to our office? _____

1. Has your child been checked by a Doctor of Chiropractic? _____ Who? _____

Were x-rays taken? _____ Who is your regular pediatrician? _____

2. Did you have ultrasound during this pregnancy? _____ Frequency _____

- Place of birth: Home/ Birthing Center/ Hospital
- Provider: Midwife/ OB-Gyn/ Other _____
- Type of Birth: Vaginal/C-section. Was anesthesia used? _____ Type _____
- Was labor induced? _____ If yes, why? _____
- What position did you deliver in: Squatting/ On Back
- Birth Trauma: Doctor assisted/ Twisting, Pulling/ Vacuum Extraction/ Forceps
- Newborn trauma (medical procedures and tests) _____

3. Did you breast-feed your child? ____ yes ____ no How long? _____

4. Can you recall any such jolts, falls or traumas to your child? ____ Please Describe: _____

Any fractures or dislocations? _____

5. What sports does your child play? Soccer/ Football /Gymnastics/ Karate/ Hockey/ Lacrosse/ Basketball/ Dance/
Wrestling/ Baseball/ Other _____

6. Other than the 5 hours per day spent sitting in the classroom, does your child spend additional prolonged time sitting?

____ yes ____ no Is it in front of a computer or TV? _____

7. How would you rate your child's diet? _____

Does your child consume artificial sweeteners? ____yes ____no Fluoridated water? ____yes ____no

8. Circle any of the following conditions your child has suffered from:

Colic, Irregular Sleeping Patterns, Night Terrors, Seizures, Tantrums, Ear Infections, Allergies, Asthma, Headaches,
Poor Digestion, Repeated Infections or Colds, Bed Wetting, Learning Disorders, Emotional Disorders, ADD or ADHD,
Other: _____

9. How often has your child been treated with drugs? _____

Is your child currently on any medications? (Please list) _____

Any surgeries? _____

10. Did your child experience any behavioral, emotional or physical changes within 3 months after any shots? _____

Describe _____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. _____ to administer care as deemed necessary to my son/daughter.

Signed _____ Date _____

Witnessed _____ Date _____

Diagnosis:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Articular Restrictions

- _____ C0-
- C1 _____ C1-
- _____ C2-
- C3 _____ C3-
- _____ C4-
- C5 _____ C5-
- _____ C6-
- C7 _____ C7-
- T1 _____ T1-
- T2 _____ T2-
- T3 _____ T3-
- T4 _____ T4-
- T5 _____ T5-

- SupC Act
- Prot Sup T
- DropD Kick
- Logan R L

Service Codes:

- M MB MS
- O OF OE
- EF EE ED
- 1-Theraband NMR TE
- 2-Theraband Icepack Lumbar Pillow
- 3-Theraband Biofreeze _____