DRAGONFLY
WELLNESS

Pediatric Case History (0-13 years of age)

All information contained in this form is strictly confidential.

Full Name: _____ **Date of Birth:** _____

Name(s) of Parent/Guardians: _____ **Sex:** ☐ **Male** ☐ **Female**

Address: _____

Phone (M): _____ **Phone (H):** _____

Parent's Email: _____

Siblings names and ages: _____

Are you a member of a health fund? Y/N: ☐ **Which fund** _____

Who may we thank for referring you to our practice? ☐ **friend** ☐ **family** ☐ **internet** ☐ **other**

Name of friend or family member: _____

Current Health

Reason for your child's visit today:

When did this begin: _____

(Please describe the pain by circling the picture below)

Can they describe the pain? ☐ **Sharp** ☐ **Dull** ☐ **Ache** ☐ **Burning** ☐ **Throbbing** ☐ **Deep** ☐ **Shooting**

Frequency of the complaint: ☐ **Constant** ☐ **Intermittent** ☐ **Occasional** ☐ **Rare**

Since the problem started, is it? ☐ **About the same** ☐ **Getting better** ☐ **Getting worse**

It interferes with: ☐ **School** ☐ **Sleep** ☐ **sport** ☐ **Leisure** ☐ **other**

Additional Complaints (Please describe): _____

Previous Health

Regarding your child's health:

Has your child had any serious health problems? Y/N: ☐ **(describe):** _____

Have they broken any bones? Y/N: ☐ **(describe):** _____

Has your child ever been in any accidents, or had any major sporting injuries or falls? Y/N: ☐

(Describe): _____

Has your child ever been hospitalzied or had any operations? **(describe):** _____

Do they have any allergies Y/N: ☐ **(describe):** _____

Name and address of medical doctor: **(Name)** _____

(Address) _____

Has your child seen a chiropractor before? Y/N: ☐ **Name of Chiropractor:** _____

Location: _____ **Date of last adjustment:** _____

What were the results of the care: ☐ **excellent** ☐ **satisfactory** ☐ **fair** ☐ **did not help** ☐ **worsened**

Did the Chiropractor take x-rays? Y/N: ☐ **Did they have a thorough examination?** Y/N: ☐

What do you want to gain with Chiropractic Care? _____

Medical History

Is your child up to date on vaccinations? Y/N: **(Describe):** _____

How many doses of antibiotics has your child taken? (past 6 months and total in lifetime):

_____

Has your child had any prescription medication? Y/N:

List medications: _____

Is your child currently taking any medications or supplements? _____

Has your child been diagnosed with any of the following:

- ☐ ADHD
- ☐ Allergies
- ☐ Appendicitis
- ☐ Asthma
- ☐ Bed Wetting
- ☐ Chicken Pox
- ☐ Colic/Reflux
- ☐ Constipation/diarrhea
- ☐ Ear Infections
- ☐ Headaches
- ☐ Learning Disorders
- ☐ Measles or Mumps
- ☐ Poor Coordination
- ☐ Poor Sleep
- ☐ Back Pain or Scoliosis
- ☐ Seizures
- ☐ Falls onto head
- ☐ Recurring Sicknesses

Prenatal and Newborn History

Complications during pregnancy? Y/N: **(Describe)** _____

Ultrasounds during pregnancy? Y/N: **(Describe)** _____

Medication during pregnancy? Y/N: **(Describe)** _____

Location of birth? ☐ **Home** ☐ **Hospital** ☐ **Birth Center**

Type of Birth? ☐ **Vaginal** ☐ **C-section** ☐ **Induced** ☐ **Emergency** ☐ **Suction or Vacuum** ☐ **Normal**

☐ **Breech** ☐ **Posterior** ☐ **At term** ☐ **Premature** ☐ **Overdue**

Any complications Y/N: **(Describe)** _____

Any genetic disorders or disabilities at birth? Y/N: **(Describe)** _____

Birth Weight _____ **Birth Length** _____ **APGAR score** _____

Your baby's feeding history:

Breast Fed? Y/N: **How long?** _____

Formula Fed? Y/N: **How long?** _____

Introduced to solids: _____ **Cows milk:** _____

Any food allergies or intolerances? _____

Your child's developmental history

(***The following milestones are important developmental times when your child's spine is very vulnerable to stress and should be routinely checked for spinal problems by a Doctor of Chiropractic.***)

What age could your child respond to:

Sound: _____ **Visual stimuli:** _____ **Hold head up:** _____

Sit: _____ **Crawl:** _____ **Stand:** _____ **Walk:** _____

Family History

Is there a family hisotry of scoliosis or other spinal problems? Y/N:

Please list: _____

Is there a family hisotry of other diseases/conditions? Y/N:

Please list: _____

Your Child's Habits

Does any of the following apply to your child?

☐ **High impact sports** ☐ **Falls onto the head** ☐ **Poor posture** ☐ **Heavy backpack** ☐ **Rounded shoulders**

☐ **Too much screen time** ☐ **Poor sleep posture and/or quality** ☐ **Poor diet/exercise**

PLEASE READ AND SIGN (In the presence of the Chiropractor):

I have read the above information and certify the statements made are true and correct to the best of my knowledge and I agree to allow this office to examine my child for further evaluation, to refer out for x-rays, if required, and to provide them with chiropractic care.

Patient's/Guardian's Signature: _____ **Date:** _____