Pediatric Case History

(Newborn – 12 years of age)

Welcome to Polson Family Chiropractic!! We look forward to working with your family to achieve optimum health. A patient's health is not based on symptoms or lack of symptoms. For instance, a tooth is not considered healthy when it has decay, even though there is no pain felt. A dentist checks for these "painless" cavities just as a chiropractor checks for nerve interference to maintain overall health. Chiropractic does not cure any disease or treat symptoms alone. Rather, our chiropractic analysis will focus on removing nervous system interference, caused by physical, emotional and/or chemical stressors, allowing the child's body to properly express health. To help us serve you better, please complete the following:

Identification and Contact Information

Child's Name ____Age_________ DOB ____________________ M/F

Address _______________________________________ City ________________________ State _____ Zip _____________

Home Phone _____________________________________ Cell Phone ____

Email Address ____

Mother's Name ___________________________________ Occupation ____

Father's Name ____________________________________ Occupation ____

Child's Insurance Provider ____________________________________ Policy # ___________________________________

Child's Primary Care Physician ____

Who can we thank for referring you? ____

Medical History

What concerns you today about your child's health and well-being?

1. ____
2. ____
3. ____
4. ____

Do you feel your child's present diet, environment, and/or physical activity level are related to his/her present health challenge? Yes ___ or No ___. If yes, explain:____

How long has this condition been bothering your child? ____
Is this condition (check one) – □ getting worse □ staying the same □ slowly improving □ quickly improving
What aggravates the condition? ____
Is the condition interfering with: □ school □ sleep □ concentration □ daily routine

Does your child have any of the following additional concerns?

- ○ Headaches
- ○ Sinus problems/Allergies
- ○ Restlessness
- ○ Sore or Tight Muscles
- ○ Poor Muscle Tone
- ○ Fatigue
- ○ Ear Infection(s)
- ○ Frequent Colds
- ○ Colic
- ○ Fussiness
- ○ Bed Wetting
- ○ Stomach aches
- ○ Irritability
- ○ Reflux
- ○ Anxiety
- ○ Poor Sleep
- ○ ADD/ADHD
- ○ Gas
- ○ Loss of Energy
- ○ Difficulty Crawling or Rolling
- ○ Loss of Concentration
- ○ Non-Stop Crying

Vital Health Information:

Current Weight: ___________________ Current Height or Length: ________________

Have you noticed any developmental delays with your child? ____yes or ____ no. If yes, explain:
____

Research indicates that 80% of normal childbirth results in trauma to the neck that goes undetected for many years. Also, the average child falls well over 200 times while learning to walk. Additionally, emotional stress (of the parents', as well as the child's own) can affect a child's overall health and well-being. Finally, a study showed that the cord blood of newborns contained an average of 217 neurotoxins. Chemical stressors are all around us, in our environment, the foods we eat, and the very air we breathe. The accumulation of this physical, emotional and chemical stress has an impact on a child's nervous system. We are interested in the amount of stress your child has experienced, beginning with their birth history.

Did you experience any of the following complications or interventions during pregnancy or delivery?

- High Blood Pressure
- Emotional Stress
- Gestational Diabetes
- Long Labor
- Pitocin or other induction
- Epidural
- Forceps delivery
- Vacuum delivery
- C-Section (Planned or Emergency)
- Birth Trauma
- Premature delivery
- Breech
- Breathing problems
- Cord wrapped around neck

Location of Birth: _____ Hospital, _____ Birthing Center, or _____ Home

Birth Weight ________________ Length __________________ Gestational Age at Birth ______________________

Was (is) your child □ Bottle fed (when introduced? ______), □ Breast Fed (for how long? __________), or □ both? Does (did) your child experience any problems latching or sucking? ____

Has your child been vaccinated? □ Yes □ No, □ Regular or □ Extended schedule.

Antibiotics? □Yes or □ No, # Rounds ____________

What is your child's diet like? Do they eat an excessive amount of sugar, processed foods, caffeine, sodas, junk or fast food? Do they enjoy fruits and vegetables? Is it a generally balanced diet? Are you concerned about any of this? Please describe:
____
____

Please list any medications or supplements your child is using:
____
____

What is your child's activity level? □ very active □ somewhat active □ not very active □ sedentary

Does your child play any sports? If so, please list. ____

Has your child been involved in any car accidents or other significant accidents? If so, please describe.
____
____

Has your child experienced any physical or emotional abuse or neglect or any other form of family stress? □ Yes, or □ No
Has your child been exposed to drugs, alcohol or any other chemicals during pregnancy or otherwise? □ Yes, or □ No

Is there anything else you'd like us to know about your family or your child?
____
____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment for my child. If there is a change in my child's medical status, I will inform the chiropractor.

Signature of Parent (or authorized party) ____Date __________________