CHILDREN'S CASE HISTORY

PREGNANCY/BIRTH

- Was ultrasound received during pregnancy? ___Yes ___No _____ Frequency
- Place of birth: ___Home ___Birthing Center ___Hospital
- Type of birth: ___Vaginal ___Induced Labor ___C-Section
- Was anesthesia used? ___ Type: ______________________
- Birth trauma: ___Twisting/Pulling ___Vacuum Extraction ___Forceps
- Other medical procedures: ____

BREAST-FEEDING

Was your child breast fed? ___yes ___no
If yes, how long? _____________
If no, what were the reasons? _________
____

MEDICATION

Current Medications: _____________________

Past Medications: _______________________

a. How often: ______________
b. Prescription/Over-the-Counter

VACCINATIONS

Did your child receive vaccinations? ___yes ___no
Were there any behavioral/ emotional/ physical changes resulting? ___yes ___no
If yes, please describe: _____________________

SPORTS

Football/Soccer/Baseball/Basketball/
Gymnastics/Karate/Hockey/Wrestling/
Dance/Other: ___________________

TRAUMAS/HOSPITALIZATIONS

1. __________________________________
2. __________________________________
3. __________________________________

HABITS

- ☐ Computer
- ☐ Video Games
- ☐ Watching television
- ☐ Other: _______________

DIET

Meals per day: ______
How would you rate your child's diet?
POOR / FAIR / GOOD /
VERY GOOD / EXCELLENT

CONDITIONS/SYMPTOMS

- ☐ Colic
- ☐ Irregular Sleeping Patterns
- ☐ Seizures
- ☐ Bed-Wetting
- ☐ Tantrums
- ☐ Ear Infections
- ☐ Allergies
- ☐ Asthma
- ☐ Headaches
- ☐ Poor Digestion
- ☐ Repeated Infections/Colds
- ☐ Learning Disorders
- ☐ ADD or ADHD
- ☐ Other: ________________

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. _______________ to administer care as deemed necessary to my son/daughter.
Parent's Name: ____________________________ Signature: _________________________________
Child's Name: ____________________________ Date: ___________________________