

## CHILDREN'S CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire fully and remember to bring it with you for your first appointment.

Your answers will help us determine how chiropractic care can help your child

### PERSONAL INFORMATION:

Child's Name: \_\_\_\_\_

What do they prefer to be called? : \_\_\_\_\_

DOB: \_\_\_\_\_ Weight: \_\_\_\_\_ Length: \_\_\_\_\_ APGAR: \_\_\_\_\_

Parents' Names: \_\_\_\_\_ & \_\_\_\_\_

Previous Chiropractic Care? \_\_\_\_\_ If so when and why: \_\_\_\_\_

*The human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. The healthy function of every cell, every system, and every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system.*

*From the birth process until the present, events have occurred in your child's life which may have caused interference and damage to this delicate system. Physical, emotional, and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex.*

*The following form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of your child's nervous system and therefore impair your child's inborn health and well-being.*

### PRENATAL HISTORY:

1. For Menstruating Female patients, is there a chance your child is pregnant? Y / N
2. Why are you bringing your child in for Chiropractic Care? \_\_\_\_\_
3. Who is your regular pediatrician?  
Name: \_\_\_\_\_ Practice Name: \_\_\_\_\_  
Address: \_\_\_\_\_
4. Birth related questions for children under 10 years old:
  - Did you have ultrasounds during the pregnancy? \_\_\_\_\_ Frequency: \_\_\_\_\_
  - Place of birth: Home / Birthing Center / Hospital
  - Provider: Midwife / OB-Gyn / Other: \_\_\_\_\_
  - Type of birth: Vaginal / C-Section.
  - Was anesthesia used? \_\_\_\_\_ Spinal          Epidural          Other \_\_\_\_\_
  - What position did you deliver in: Squatting / On Back / Other: \_\_\_\_\_
  - Birth Trauma: \_\_\_\_\_
  - Doctor assisted Twisting, Pulling / Vacuum Extraction / Forceps
  - Newborn trauma (medical procedures and tests) \_\_\_\_\_
5. Did you breast-feed your child? Yes \_\_\_\_\_ No \_\_\_\_\_ How long? \_\_\_\_\_  
*Repeated studies are now informing us breast-feeding develops strong and healthy immune, neurological, and digestive systems.*

6. According to the National Safety Council, approximately 50% of infants have fallen onto their heads during their first years of life. Another study reveals about a quarter of a million children are injured on playgrounds annually. Can you recall any such jolts, falls, or traumas to your child? \_\_\_\_\_  
Please Describe: \_\_\_\_\_
7. Any fractures or dislocations (what, when, how, etc.)? \_\_\_\_\_
8. Which sports does your child play? Soccer / Football / Gymnastic / Karate / Hockey / Lacrosse / Basketball / Dance / Wrestling / Baseball / Other: \_\_\_\_\_
9. 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, TV, tablet, or game console? \_\_\_\_\_
10. How would you rate your child's diet? Poor Fair Good Excellent
- Does your child consume artificial sweeteners? \_\_\_\_\_
  - Fluoridated Water? \_\_\_\_\_
11. Circle any of the following conditions your child has suffered from:  
Colic, Irregular sleeping patterns, Night terrors, Seizures, Tantrums, Ear Infections, Asthma, Allergies, (Please list) \_\_\_\_\_  
Headaches, Poor Digestion, Bloating Abdomen, Constipation/Pain or other Bowel Complaints, Thickly Coated or Patchy White Tongue, Red Rings around Anal Area, Itchy Genital Area, A Chronic Hair or Foot Odor, Muscle Aches or Weakness, "spacey" or "zoned out" look in eyes. Repeated Infections or Colds, Bed Wetting, Learning Disorders, Emotional Disorders, ADD or ADHD, Eczema, Headaches, Unexplained Aches or Pains If so, where? \_\_\_\_\_  
Other Medical Diagnoses or anything else you are concerned about \_\_\_\_\_
12. How often has your child been treated with drugs/antibiotics? \_\_\_\_\_
- What drug(s), for what, and when? \_\_\_\_\_
  - Were you informed of their adverse reactions? \_\_\_\_\_
  - If it was an antibiotic, was your child recommended to take a probiotic? \_\_\_\_\_
13. Any Surgeries? \_\_\_\_\_ If so, for what and when? \_\_\_\_\_
14. The child's immune system, like all other developing systems of the body is both intricate and delicate. It strives for a state of homeostasis and balance in the body. Long term, adverse effects from interfering with this process with artificial immunizations are just being uncovered.
- Were you adequately informed of the risks of vaccinating your child? \_\_\_\_\_
  - Did your child experience any neurological, developmental, behavioral, emotional, or physical changes within 3 months after any shots? \_\_\_\_\_
  - If so please describe \_\_\_\_\_
  - Was it reported by your or your doctor? \_\_\_\_\_
  - Was it reported to the Vaccine Adverse Event Reporting System (VAERS)? \_\_\_\_\_

***Today, we are becoming more aware of how current technological lifestyles and practices expose our children's nervous systems to continuous stresses. These result in Vertebral Subluxations.***

***Current scientific research is showing the direct relationship between the function of the nervous system and immune system function. The integrity of the nervous system is therefore imperative to a healthy immune system in your growing child.***

***Your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic, the only health care provider qualified to locate, analyze and correct the Vertebral Subluxation Complex. Correction of the Subluxation with the Chiropractic Adjustment is the beginning of greater health and well-being for your child.***

## **AUTHORIZATION FOR CARE OF A MINOR**

I hereby Authorize Dr. Louis Fernandez & Dr. Tiffany Fernandez, and any licensed chiropractors affiliated with In Good Hands Chiropractic for coverage services, to administer care as deemed necessary to my son/daughter.

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_