Lentini Chiropractic Pediatric Case History

Date ___/___/___ **Child's Name** _____ **Date of Birth** __/___/___

Age ____ **Sex** M / F **Child's Soc. Sec. #** _____ **Mother**_____

Address_____ **Zip**_____ **Father**_____

Birth weight ____ Current weight ___ Birth Length ____ Current Length _____ # Siblings ____

Birth History:
Delivery: __ Natural ___ Drug Induced ___ Drug Assisted __ C— Section __ Hospital __ Home
Labor: ___ 0-2 hours ___ 2-6 Hours ___ 6-12 hours ___ 12 + Hours

Any Complications: ___ Abnormal Birth Position (what?) _____ ___ Forceps Delivery
___ Vacuum Extraction ___ Spinal Anesthesia (Epidural) _____ Other_____

Congenital Abnormalities? Y /N What type? _____
APGAR Scores: ___ ___ Was the child ____ Jaundiced (yellow), ____ Cyanotic (blue) at birth?

Infant Feeding: ___ Breast ___ Bottle What kind of Formula? _____
# of hours sleep per night: ___ Quality of sleep: ___ Good ___ Fair ___Poor

Pediatrician _____ Address _____
Immunization History: _____

Health History:

____ Colic ___ Ear Problems ___ On Antibiotics? ____ How Many times? ____ Sleep Problem

Falls: _____ Accidents: _____ Surgery: _____

Complaints: _____

Behavior at Home: _____

School Performance (if applicable) _____

Purpose of this visit: _____

When did it start? _____ **Did anything cause it?** _____

What helps? _____ **What makes it worse?** _____

Has the child been treated or is under treatment for this condition? Yes / No
What type of treatment? _____

Consent to Examine and, if necessary, to treat a Minor	**Payment Today**
I authorize the Doctor to examine, take x-rays (if clinically necessary to further the diagnosis) and treat (if necessary) my child. Parent / Legal Guardian Signature _____ Print your name _____	(Please Check) 0 Cash 0 Check 0 MC / Visa 0 Insurance

Childs Name: _____

DEVELOPMENTAL HISTORY:

AT WHAT AGE DID THE CHILD:

_____RESPOND TO SOUND
_____FOLLOW AN OBJECT WITH HIS/HER EYES
_____HOLD HEAD UP_____SIT ALONE
_____ CRAWL_____ STAND _____ WALK ALONE

CHILDHOOD DISEASES:

_____CHICKENPOX _____ RUBELLA _____ MUMPS _____ RUBEOLA
_____MEASLES _____ WHOOPING COUGH _____OTHER: _____

HAS THIS CHILD EVER SUFFERED FROM: (please circle)

Dizziness	Backaches
Diabetes	Tuberculosis
Arthritis	Headaches
Neuritis	Digestive Disorders
Anemia	Rheumatic Fever
Poor Appetite	Hyperactivity
Bed Wetting	Convulsions
Fainting	Walking Problems
Neck Problems	Arm Problems
Joint Problems	Blood Disorders

PRESENT HISTORY (please circle)

Heart Trouble	Hypertension
Asthma	Sinus Trouble
Orthopedic Problems	Sugar Concentration
Paralysis	Broken Bones
Leg Problems	Stomach Aches
Chronic Earaches	Colds / Flu
Allergies	Constipation /Diarrhea
Behavioral Problems	Muscle Jerking
Ruptures / Hernias	"Growing Pains"

Other?

FAMILY HISTORY: _____