

**West Michigan Chiropractic Clinic, P.L.C.
Pediatric Case History**

Today's Date: _____

Patient Name: _____
 First MI Last

D.O.B.: _____ Sex: **M** **F** Age: _____ How were you referred to our office: _____

Patient's Parents/Guardians: _____ Phone (hm): _____ (wk): _____

Address: _____ City: _____ State: _____ Zip: _____

Who is responsible for this account? _____ Is the child covered by any health insurance? Yes / No
Please have a West Michigan Chiropractic team member make a copy of any insurance cards or information. Thank you.

Is this a wellness check-up or is there a health problem? _____ If there is a health
problem, please describe and include any specific symptoms: _____

Check any of the following conditions your child has ever had and list how many occurrences per day, wk, mo, or yr

	# Times		# Times		# Times
<input type="checkbox"/> ear infections	_____	<input type="checkbox"/> chronic colds	_____	<input type="checkbox"/> recurring fevers	_____
<input type="checkbox"/> asthma attacks	_____	<input type="checkbox"/> digestive problems	_____	<input type="checkbox"/> growing pains	_____
<input type="checkbox"/> colic	_____	<input type="checkbox"/> bed wetting	_____	<input type="checkbox"/> headaches	_____
<input type="checkbox"/> headaches	_____	<input type="checkbox"/> seizures	_____	<input type="checkbox"/> allergies	_____
<input type="checkbox"/> car accident	_____	<input type="checkbox"/> ADHD	_____	<input type="checkbox"/> scoliosis	_____
<input type="checkbox"/> back pain	_____	<input type="checkbox"/> croup/cough	_____	<input type="checkbox"/> difficulty sleeping	_____

Are there any other conditions your child has that are not listed here? _____

Yes / No Are there any health problems with anyone at home? Please describe: _____

Yes / No Is your child on any prescription or over the counter medications? Please list: _____

If so, how often has the child been given these? (once or multiple times a day, week, month, or year) _____

Were there any complications in the birth process? (caesarean, forceps, vacuum extraction, induction of labor, anesthesia, epidural, etc.) Please describe: _____

Yes / No Has your child received any vaccinations?

Yes / No Any adverse reactions noticed upon receiving? If yes, please describe? (fever, restlessness, irritable, etc.) _____

Yes / No Has your child been developing normally? If not, please describe: _____

Yes / No Has your child ever fallen from ANY height? Please describe: _____

Yes / No Has your child ever been involved in any kind of accident? (at the playground, daycare, bicycle, sports, auto accident, etc.) _____

Are there any other concerns that you may have regarding your child's condition, development, or care that we can be of assistance? _____