CHILD CASE HISTORY

Date / /

Personal Data

Name _____ Birthday / /

Address _____ Home Phone _____Parent cell _____

City _____ State _____ Zip _____ Parent wk _____

Parent name(s) _____ Age of Siblings _____

Parent Email(s) _____

Who referred you to our office? _____

Please check any of the following statements that describe(s) your current goals for your child's health and well being:

- ❑ I am only concerned about relief of a particular symptom.
- ❑ I am concerned about relief of a particular symptom, and preventing its return.
- ❑ I want my child to perform at the highest capacity.

CAUSE

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.

This form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of your nervous system and therefore impair your inborn health and wellbeing.

The Vertebral Subluxation Assessment

1. **What is your main concern, if any, about your child's health?**_____ **Has your child been checked by a Doctor of Chiropractic? When?** _____ Chiropractor's name_____
   Why did you discontinue care? _____
   Were x-rays taken? _____ Name of your regular pediatrician_____

2. **Experts around the world agree: the birth process as we know it may cause extensive neurological trauma, damage, and even death to the infant.**
   - Did you have ultrasound during this pregnancy? _____ Frequency _____
   - Place of birth: Home/Birthing Center/Hospital
   - Provider: Midwife/ OB-Gyn/ Other _____
   - Type of Birth: Vaginal / C-section. Was Anesthesia used? _____ Type: _____
   - Was labor induced? _____ If yes, why? _____
   - 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) _____
     _____
     _____

3. **Repeated studies are now informing us breast-feeding helps to develop strong and healthy immune, neurological, and digestive systems.**

   Did you breast feed your child? _____ yes ____ no. How long?_____
   Was your decision supported by your health care provider? _____ yes _____ no.
   Was your decision supported by your family? _____ yes _____ no.

4. **According to the National Safety Council, approximately 50% of infants have fallen onto their heads during their first years of life. Another study reveals ¼ million children are injured on playgrounds annually.**

   Can you recall any such jolts, falls or traumas to your child? _____ yes _____ no
   Please describe: _____
   _____

5. **Does your child play sports? Please circle: Soccer/ Football/ Gymnastics/ Karate/ Hockey/ Lacrosse/ Basketball/ Dance/ Wrestling/ Baseball/ Sensory Integration Therapy?**

6. **Other than the 5 hours per day spent sitting in the classroom, does your child spend additional prolonged time sitting? _____ yes _____ no _____N/A. Is it in front of a computer/game/ TV?**

7. **How would you rate your child's diet?** _____

   Does your child consume artificial sweeteners? _____ Fluoridated water? _____

8. **Circle any of the following your child has suffered from:**

   Colic, Reflux, Irregular Sleeping Patterns, Night Terrors, Seizures, Tantrums, Ear Infections, Allergies, Asthma, Headaches, Poor Digestion, Repeated Infections or Colds, Toe Walking, Repeated Ankle Sprains, Walking With One Foot Turned Out, Bed Wetting, Learning Disorders, Emotional Disorders, ADD or ADHD, Sensory Processing Challenges, Other _____

9. **How often has your child been treated with drugs?** _____

   Were you informed of their adverse reactions and side effects? _____
   If it was an antibiotic, was you child cultured for its use? _____ yes _____ no
   Is your child currently on any medications? (please list) _____
   Any surgeries? _____

10. **Did your child receive vaccinations:** _____yes___no

    Were you adequately informed of the risks of vaccinating your child? _____ yes _____ no
    Did your child experience any behavioral, emotional or physical changes within 3 months after any shots? _____ yes _____ no. Describe _____
    Was it reported by you or your doctor? _____ yes _____ no.

On a scale of 1-10, with 10 being optimum, how would you rate your child's current health? _____
If his or her health does not rate a 10, how likely is it that it will reach a 10 in the foreseeable future? _____
What other health care is your child receiving?

I hereby authorize Lisa Lewis, D.C. and whomever she may designate as assistants to administer chiropractic adjustments and treatment to my minor son/daughter _____.

The patient information given is true and complete to the best of my knowledge.

I understand that all services are to be paid in full at the time of the service, unless other arrangements have been made and agreed upon in writing.

Relationship to child: _____. _____

Parent/guardian signature ***Date***

Well done! Welcome to the practice!!