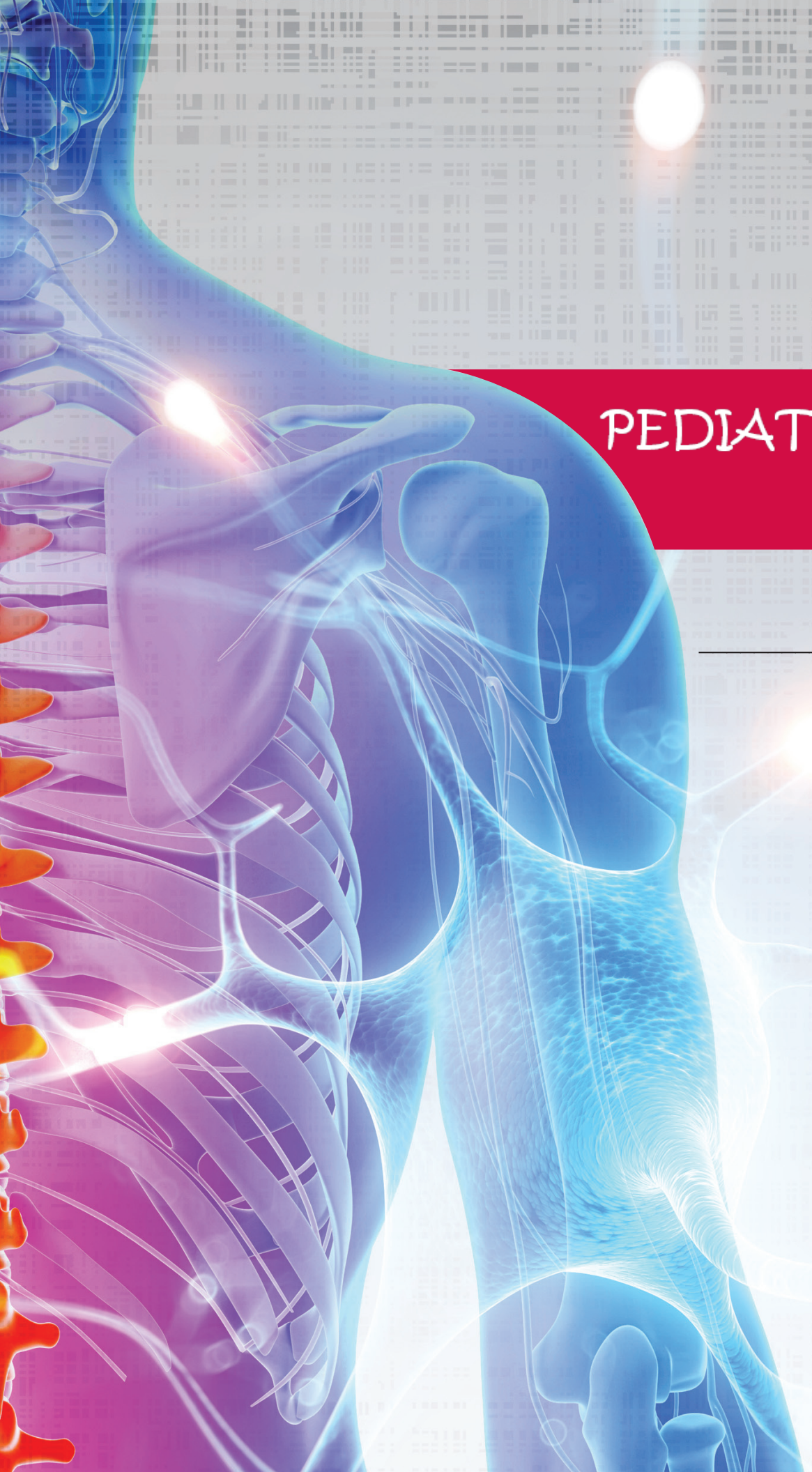

PEDIATRIC CASE HISTORY

PREPARED FOR:

_____

LIFE UNIVERSITY

THE NEW RENAISSANCE

Chiropractic Coaching for

PURPOSE, PASSION, & PROSPERITY

Name: _____ Date: _____

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that have resulted in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

ABOUT YOUR CARE

Chiropractic provides three types of care. The first is Conditioned Based Care, which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins Corrective Care, which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to Wellness Care. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

LOSS OF WELLNESS

At birth, when your nerve system is first damaged, your wellness begins to decrease and the journey to ill health starts.

Yes	No	1. Pregnancy	Patient Comment (if answer is yes)	Chiropractor's Comments
		Did your mother:		
☐	☐	Have a proper diet?	_____	_____
☐	☐	Exercise?	_____	_____
☐	☐	Smoke or drink alcohol?	_____	_____
☐	☐	Take any medication/vaccines	_____	_____
☐	☐	Experience any falls/injuries during pregnancy?	_____	_____
☐	☐	Experience any physical/mental abuse?	_____	_____
☐	☐	Get ultrasounds done? How many?	_____	_____
☐	☐	Have abnormal findings (blood, ultrasound, other)?	_____	_____
☐	☐	Have problems during pregnancy?	_____	_____
		2. Birth Process		
☐	☐	Was the delivery long/difficult?	_____	_____
☐	☐	Breech/cephalic presentation?	_____	_____
☐	☐	Forceps? Vacuum? (specify)	_____	_____
☐	☐	Caesarean section? (planned or emergency)	_____	_____
☐	☐	Hospital Birth?	_____	_____
☐	☐	Was labour induced?	_____	_____
☐	☐	Mother given drugs during delivery?	_____	_____
☐	☐	Problems during labour/delivery?	_____	_____
☐	☐	Congenital abnormalities	_____	_____
☐	☐	Injuries at birth? (e.g. torticollis)	_____	_____
		3. Growth and Development		
☐	☐	Were you breastfed? How long?	_____	_____
☐	☐	Developmental milestones reached on time?	_____	_____
☐	☐	Did you fall from crib, bed, change table etc.?	_____	_____
☐	☐	Childhood diseases? (ear infections, measles etc.)	_____	_____
☐	☐	Were you vaccinated (fully/partial)?	_____	_____
☐	☐	Were you picked on by siblings?	_____	_____
☐	☐	Mental/physical/sexual abuse?	_____	_____
☐	☐	Spanking (How?)	_____	_____
☐	☐	Were you yanked by your arm?	_____	_____
☐	☐	Did you fall off skateboard/skates/bicycle?	_____	_____
☐	☐	Did you fall from playground apparatus?	_____	_____
☐	☐	Any other traumas? What? When?	_____	_____
☐	☐	Did you have surgery/hospital visits?	_____	_____

Name: _____ Date: _____

LOSS OF WHOLE BODY HEALTH

As layers of damage increase, you will probably experience symptoms and random bouts of sickness.

Yes	No		Patient Comment (if answer is yes)	Chiropractor's Comments
☐	☐	Drugs prescriptive/non-prescriptive?	_____	_____
☐	☐	Reactions to vaccines or drugs?	_____	_____
☐	☐	Do you have stress about school or separation anxiety?	_____	_____
☐	☐	Mental stress?	_____	_____
☐	☐	Have you been teased or bullied?	_____	_____
☐	☐	Sleeping habits (nightmares/insomnia, etc.)	_____	_____
☐	☐	Eye problems?	_____	_____
☐	☐	Hearing problems?	_____	_____
☐	☐	Teeth problems?	_____	_____
☐	☐	Exercise regularly? Describe	_____	_____
☐	☐	Hobbies/Sports injuries?	_____	_____
☐	☐	Have you ever been in vehicular accidents?	_____	_____
☐	☐	Were you taught proper body movement and care?	_____	_____
☐	☐	Diet (Do you eat healthy food? Special diet?)	_____	_____
☐	☐	Food allergies/intolerances?	_____	_____
☐	☐	Any major life changes (separation, move,	_____	_____
☐	☐	change schools, death in family)?	_____	_____

SYMPTOMS AND ILL HEALTH (PRESENT STATE OF ILL HEALTH)

Years of untreated damage shows up as acute or chronic symptoms. Check of any of the symptoms you have experienced:

☐ Difficulty Nursing	☐ Neck pain/Stiffness	☐ Behavioural Problems	☐ Poor appetite/Fussy eater
☐ Colic/Excess crying	☐ Back pain/Stiffness	☐ Easily Overstimulated	☐ Stomach-ache/Reflux
☐ Flat Head	☐ Numbness/Tingling	☐ Difficulty concentrating	☐ Constipation/Diarrhea
☐ Ruptures/Hernia	☐ Arm/leg pain	☐ Fussiness/Irritability	☐ Bedwetting
☐ Torticollis	☐ Joint pain	☐ Low energy	☐ Difficulty sleeping
☐ Seizures/Convulsions	☐ Muscle pain	☐ Depression	☐ Sensory seeking
☐ Skin issues (eczema, hives)	☐ Scoliosis	☐ Anxiety/High stress	☐ Frequent/Prolonged colds
☐ Growing pains	☐ Poor posture	☐ Headaches	☐ Ear-aches/Ear infections
☐ Poor coordination	☐ Poor memory	☐ Can't sit still	☐ Dizziness/Loss of balance

SYMPTOMS AND ILL HEALTH (PRESENT STATE OF ILL HEALTH)

Major complaint: _____

When did pain or problem start? _____

Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent Is condition getting progressively worse? ☐ Yes ☐ No

What activities aggravate you condition/pain? _____

Is condition worse during certain times of the day? ☐ Yes ☐ No If so, when? _____

Is this condition interfering with: ☐ School ☐ Sleep ☐ Routine ☐ Other : _____

Other doctors seen for this condition? _____

Treatments/home remedies? _____

Are you under care for other conditions? ☐ Yes ☐ No

If yes, please explain: _____

Name: _____ Date: _____

FAMILY HISTORY

Father:
- ☐ Heart disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Other: _____

Mother:
- ☐ Heart disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Other: _____

Relatives:
- ☐ Heart disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Other: _____

PATIENT INFORMATION

Name: _____ Care card # _____ Date: _____

Gender: ☐ Male ☐ Female Date of Birth: _____ (Age: ____)

Address: _____ City: _____Province:_____ Postal Code: _____

Mother's name: _____ Father's Name:_____

Mother's occupation: _____ Father's occupation: _____

Mother's cellphone# _____ Father's cellphone # _____

Home phone # _____ Email: _____

Names and ages of siblings: _____

Have you ever received chiropractic care? ☐ Yes ☐ No Name of your family doctor: _____

Have you ever been in an accident? ☐ Yes ☐ No ☐ Auto When: _____

Nature of accident: _____

Did you require hospitalization? ☐ Yes ☐ No Did you miss days of school as a result? ☐ Yes ☐ No How many? _____

Is insurance involved? ☐ Yes ☐ No Which company? _____

Attorney's name: _____ Claim number: _____

If you were referred, by whom? _____

Comments (office use only):

CONSENT FOR CARE OF A MINOR

I, _____ authorize Family Wellness Chiropractor, Dr. Sabrina Chen-See and staff to render care for my minor child, _____ .

_____ _____

Parent/Guardian Signature Date

_____

Witnessed