

**CONFIDENTIAL PATIENT CASE HISTORY**  
**PEDIATRIC CASE (NEWBORN-16 YEARS OF AGE)**  
**absolute health chiropractic**

46 South Street, Wrentham, MA 02093  
ph: 508.384.0944 f: 508.384.0977

Dear Parent:

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help your child. If we do not sincerely believe the condition will respond to care, we will not accept the case. Thank You.

**Personal Information**

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_  
Pediatrician \_\_\_\_\_ May we contact him/her for this case?  yes  no  
Parent/Guardian Name \_\_\_\_\_ Home Telephone \_\_\_\_\_  
Work Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Referred by \_\_\_\_\_

**Birth History**

Delivery:  Vaginal  Forceps  Vacuum Extraction  C-Section  
Infant Feeding:  Breast  Bottle  Formula  
APGAR Score \_\_\_\_\_ Congenital Anomalies \_\_\_\_\_

**Health Information**

Is your child here for:  Wellness Check-up  Specific Complaint  
Please Explain \_\_\_\_\_

How long has your child had this condition?  
 1 week  2-6 weeks  2-4 months  greater than 4 months  
Has your child had similar conditions in the past?  yes  no  
Is the condition getting progressively worse?  yes  no  
What activities aggravate the condition? \_\_\_\_\_  
Is the condition interfering with:  School  Sleep  Daily Routine  
Other Doctors/Specialists seen for this condition \_\_\_\_\_  
Drugs your child now takes:  Over the Counter Pain Meds  Allergy Meds  Other \_\_\_\_\_

Vitamins/Supplements your child now takes \_\_\_\_\_

Has your child been in an auto accident?  yes  no If so, describe \_\_\_\_\_

Has your child had any other personal injury or accident?  yes  no If so, describe \_\_\_\_\_

List any surgical operations and years \_\_\_\_\_

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