Date: _____/_____/_____

DIVINE CHIROPRACTIC

Children's Case History

(Please Print)
Childs's Name: _____
First Last
Birth Date: _____/_____/_____ Age: _____ Current WT & LGTH: _____

Mother's Name: _____
First Last
Father's Name: _____
First Last
Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

Email: _____

Pregnancy History: (check all that apply)

☐ Morning Sickness ☐ Indigestion ☐ Swollen Ankles ☐ Back Pain ☐ Anemia
☐ Thyroid Problems ☐ High Blood Pressure ☐ Abnormal Bleeding ☐ Diabetes ☐ IVF
☐ DTap/Flu Vaccine ☐ Ultrasounds #:____ ☐ Miscarriages ☐ Other illness: _____
☐ Other (explain): _____

Place of Birth: ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other_____

Length of Labor: _____ Sedation or anesthesia: _____

Type of Birth:(circle) Vaginal , Cesarean Other interventions: (forceps, vacuum) _____

Problems with Delivery or Labor: _____

_____

Was Child Cyanotic (Blue Baby): _____ Jaundice (Yellowish): _____ APGAR scores: _____

Birth Weight: _____ Birth Length: _____

Describe Birthmarks, If Any: _____

Immunizations / Medications / Other Toxins: _____

_____

Have you chosen to vaccinate your child? ☐ Yes ☐ No

Family History: (Check one of the following)
☐ Retardation ☐ Diabetes ☐Epilepsy ☐ Allergies ☐ Other:
_____

_____

Type of Feeding: ☐ Breast ☐ Bottle ☐ Formula (Brand Name) _____

Child's Symptoms and/or Parent's Comments: _____

_____

_____

_____

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

☐ Allergies	☐ Breathing Problems	☐ Frequent Colds	☐ Skin Problems	☐ Other
☐ Asthma	☐ Constipation	☐ Headache	☐ Sleeping Disorders	_____
☐ Attention Problems	☐ Colic	☐ Hyperactivity	☐ Tubes in the ears	_____
☐ Bed Wetting	☐ Digestive Problems	☐ Irritability	☐ Vision Problems	_____

Has your child ever:	Yes	No	
- Taken Antibiotics?	☐	☐	_____
- Been hospitalized?	☐	☐	_____
- Had a severe fall?	☐	☐	_____
- Been in a car accident?	☐	☐	_____
Is your child			
- Accident prone?	☐	☐	_____
- Had surgery: Please Explain..	☐	☐	_____
- Currently taking any medication?	☐	☐	_____
- Has difficulty interacting with others?	☐	☐	_____

Have you or anyone else noticed that your child is nervous, has twitches, shakes or exhibits rocking behavior?

_____

_____

What Changes (if any) in your child's health or behavior would you like accomplished?

_____

_____

AUTHORIZATIONS

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.
I authorize the use of this signature to allow the insurance companies to pay Montecito Chiropractic directly and any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors in the chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am personally responsible for all bills incurred at the office. The Dr will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will became immediately due and payable. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

_____ _____

Signature of Parent or Guardian Date Signed