KEOUGH
CHIROPRACTIC

Child's Case History

Please Print

Patient Information

Child's Name_____Date of birth _____

Mother's Name_____Father's Name _____

Address_____City_____State_____Zip _____

Home Phone_____Cell phone _____ Referred By_____

Email Address _____ Insurance Company_____

Mother's History

Tell me about your prenatal time:

Did you exercise?____Y____N please explain _____

Did you drink alcohol?____Y____N please explain _____

Did you take drugs?____Y____N please explain _____

Did you eat regularly?____Y____N please explain _____

Did you have any spinal pain or problems during you pregnancy?____Y____N please explain

_____

Labor

How long was labor? _____ Was labor artificially induced?_____

Birth Weight_____ Birth Length_____

Would you say it was____Easy____Hard____very Hard

Did you have a spinal block / Epidural?____Y____N

How did you deliver the child?____on back____On all fours____Squatting____Sitting up in birthing chair____other

Did the doctor grasp/pull on the child's head?____Y____N

Did you notice if the doctor twisted?____Y____N

Were forceps used?____Y____N

Do you remember the APGAR score?____Y____N If so, what was it? _____

Any complications? _____

Baby's History

Was this child breastfed?____Y____N How long? _____Did this child have any unusual or strange habits or behaviors as a newborn?_____

Child's Case History (cont.)

Please Print

Colic? ___Y____N

Fussy? ___Y____N Alert? ___Y____N Happy?____Y____N

Did child have shots (immunizations)?____Y ___N

Did child crawl?____Y____N Beginning at what age?____months

Was child in a walker? ___Y____N How long?_____

For how long did the child crawl? _____

At what age did child begin to walk? _____

Did you notice anything unusual about the child's efforts to learn to walk?____Y ___N

Did the child fall a lot? ___Y_____N

Were there any particularly hard falls that you recall? ___Y_____N

If so, please explain: _____

Young Child

Ear infections?_____Y____N

Colds?_____Y____N

Mucus/Sinus trouble? ___Y____N

Falls? ___Y____N

Collisions (Automobile)? ___ Y ___N

Anything else you have noticed about your child that you think is unusual:

_____

_____

List any medications, past or present:

_____

_____

Any diagnosed diseases:

_____

_____

Signature of Mother, Father, or Legal Guardian _____ Date _____

Patient Symptoms Questionnaire

Please Print

Patient Name:_____ **Date:** _____

Symptoms

1. What is your number-one problem or the one area of greatest pain? _____

_____

2. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt.

If your pain varies from day to day, please circle two numbers to indicate a range of your pain. **0 1 2 3 4 5 6 7 8 9 10**

3. When did this problem/pain start?_____ ____Gradual_____ Sudden_____Progressive

4. What do you think caused this problem? _____

5. How often do you experience the pain?

____ 1-2 hours per day_____ About half of the day_____ Most of the day_____The pain never goes away

6. How does the pain affect your daily activities?

____ It does not affect my daily activities_____ I have had to change how I do things

____ I have had to stop doing some of my daily activities_____ I am unable to perform daily activities

7. What increases your pain? _____

8. What decreases your pain? _____

9. Have you ever experienced this problem before? **Y N** When? _____

10. List any other complaints currently bothering you and rate your pain level for each using the same scale as above.

a._____ 0 1 2 3 4 5 6 7 8 9 10
b._____ 0 1 2 3 4 5 6 7 8 9 10
c._____ 0 1 2 3 4 5 6 7 8 9 10
d._____ 0 1 2 3 4 5 6 7 8 9 10

If you have experienced any of the following conditions in the **past** mark a **"P"** on the line provided. If you are **currently experiencing** any of the following conditions please mark a **"C"** on the line provided. (check all that apply)

___ heart attack	_ stroke	_ arthritis	_ gall bladder trouble
___ diabetes	_ glaucoma	_ fainting spells	_ kidney stones
___ difficulty with urination	_ bloody stools	_ difficulty with bowel movements	
___ prostate trouble	___anemia	_ cancer	_ asthma
___ AIDS	_ ulcers	_ diverticulosis	_ menstrual cramping
___ dizziness	___loss of memory	_chest pain	_ shortness of breath
___constipation	___diarrhea	_ general fatigue	_ sudden weight loss
___ nausea	___muscle cramping	___ soreness in joints	_ loss of hearing
___ ears ringing	___headache	_ migraine	_ epilepsy
___ gout	___tuberculosis	_ syphilis	_ sprained ankle R L
___ knee/hip replacement		_ broken bones (specify)	_____

Patient Symptoms Questionnaire (cont.)

Please Print

Patient Name:_____**Date:** _____

General Activities (check all that apply)

___ sleep on waterbed ___read in bed _ fall asleep in recliner/on couch
___ sleep on stomach ___use two or more pillows to sleep with
___ needlepoint/knitting ___sewing
___ lift weights/wt. mach. ___play video games (___ hrs per day)
___ exercise_____x/wk ___jog ___ x/wk _ computer use (_____hrs per day)
___ swim ___use elliptical _ watch television (_____hrs per day)

Please add anything else you would like the doctor to know:

_____
_____
_____

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ **Date** _____
(signature of parent if the patient is a minor)

Doctor's comments: _____
_____
_____
_____
_____
_____

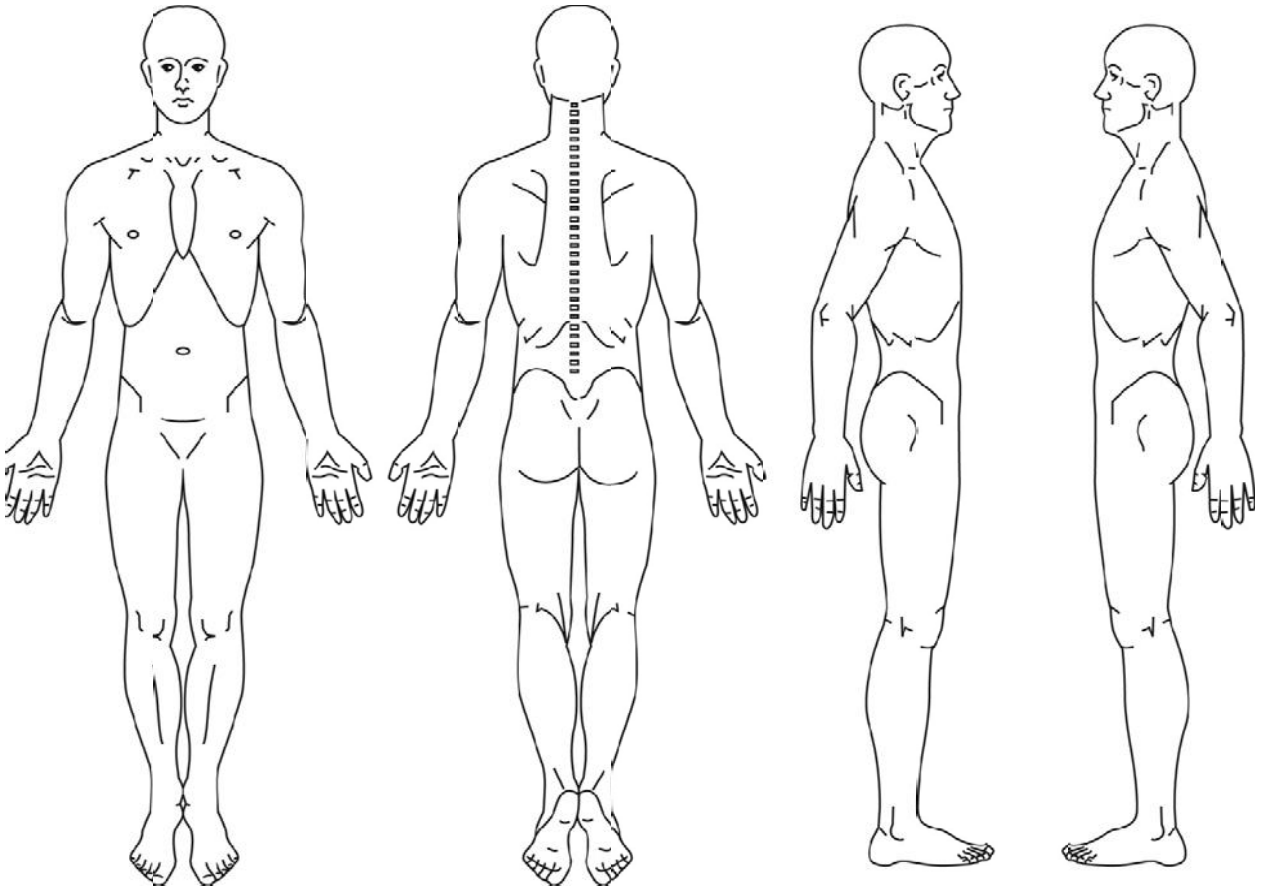
Pain Diagram

Please Print

Patient Name:_____ **Date:** _____

Please complete the following "Pain Diagram" by using the letters below to indicate on the diagram your areas of pain:

(P) Pain **(T) Tingling** **(N) Numbness** **(B) Burning** **(S) Stiffness**



Notes:

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