Cornerstone **CHIROPRACTIC**

804 N. 16th Street, Montevideo, MN 56265 Ph. 320.269.3211

Name: ___________________________ *DOB:* ________________ *Date:* _____________

Confidential Pediatric Patient Case History

Please complete this questionnaire as thoroughly as possible so we can learn about your child's health. Thank you!

Address ______________________________ City ________________ State ______ Zip _________

Home Phone ________________ Work Phone ________________ Cell Phone __________________

E-mail Address ____________________________________ **Gender**: □ Male □ Female

Parents' Names: ____

Preference for Appointment Reminders & Other General Contact:

□Phone (□Home □Cell □Work) □Email □Text (Need Cell Company for text:_______________)

Preferred Language: □ English □ Spanish □ Other: ____________________

Race & Ethnicity: □ White □ Hispanic or Latino □ Black or African American □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Pacific Islander □ Other or Decline to answer

Social Security Number ____________________ One Parent's SSN ____________________________

Who referred you to us? ____

How else did you hear about us? ____

Birth Weight: ____________________ **Current Weight:** ______________________

Birth Length: ____________________ **Current Length/Height:** __________________

Present Health:

What is your primary concern for your child's health? ____

If your child is experiencing a symptom, please answer the following:

1. When did it begin? ____
2. How did it happen? ____
3. How often does it affect your child? □constant □intermittent
4. Symptom severity is currently: □mild □moderate □severe
5. Symptom is currently: □increasing □decreasing □not changing
6. Symptom is worse in the: □morning □afternoon □night □same all day
7. What makes the symptom better? ____
8. What makes the symptom worse? ____
9. Have you seen another provider for this complaint? □yes □no
   If so, who: □Chiropractor □MD □Osteopath □Specialist □Other________________
   When and what was their treatment____
10. How do your child's symptoms interfere with their lifestyle/ daily routine or with your family's lifestyle/ daily routine? ____

Any secondary concerns for your child? ____

Has your child suffered any injuries in the past? ____

Has your child been diagnosed with any disease or condition?______________________________

Do you have a family history of:

□heart disease □cancer □arthritis □diabetes □lung conditions □high blood pressure

□stroke/vascular problems □kidney or liver conditions □other_____________

Anything else you would like the doctor to know about your child? ________________________________

____

Birth History: *(please check all that apply)*

□ Home
□ Birth Center
□ Hospital
□ Vaginal
□ Cesarean

□ Forceps
□ Vacuum
□ Normal (face down)
□ Posterior occiput (face up)
□ Breech

□ Epidural Anesthesia
□ IV Anesthesia
□ Oral Pain Drugs
□ Pitocin
□ Other drug/intervention: ___________

Hours of labor: ________________ Name of obstetrician/midwife: __________________________

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Name: ______________________ DOB: ______________ Date: ___________

Nutrition: *(please note the age/ length of time for each)*
Breastmilk ____
Bottle (pumped breast milk) ____
Formula ____
Solid Foods ____
Does your child use any nutritional supplements? ______________________________

Medical Interventions:
Name of pediatrician/ family MD: ______________________________
Please list any medications that your child is currently taking: ______________________
____ □ *No Medications*
Please list any medications your child has taken in the last year: ______________________
____ □ *No Medications*
Please list any medication allergies that your child has: ______________________
____ □ *No Known Med. Allergies*

How many prescriptions of antibiotics has your child taken in the last year? ____________
How many antibiotics in his/her lifetime? ____________

Has your child ever been hospitalized? ______________________________
Has your child ever undergone a surgical procedure? ______________________________

Vaccination History *(please check those that apply)*
□ I have opted to not have my child vaccinated
□ My child has been partially vaccinated
Vaccines given: ______________________________
Vaccines refused: ______________________________
□ My child has been fully vaccinated
□ My child has be given a flu shot
Years given: ______________________________

Review of Systems: *Please indicate if your child has had any of the following symptoms or diagnoses in the past year or in their lifetime and any treatment they received for it.*

Past year:	Lifetime:	Treatment:
□	□	Ear Infections ____________
□	□	Chronic colds/cough ____________
□	□	Recurrent Fevers____________
□	□	Asthma ____________
□	□	Allergies ____________
□	□	Colic ____________
□	□	Stomach/digestive problems ____________
□	□	Constipation ____________
□	□	Diarrhea ____________
□	□	Bed Wetting ____________
□	□	Seizures ____________
□	□	Rashes ____________
□	□	Scoliosis ____________
□	□	ADHD ____________
□	□	Learning Disorder ____________
□	□	Temper Tantrums ____________
□	□	Sleeping Problems ____________
□	□	Headaches ____________
□	□	Autism ____________
□	□	Other (please explain): ____________

Parent/ Guardian signature: ______________________________ **Date:** ______________