

# CASE HISTORY FORM BABIES & CHILDREN

CHILD _____	DATE OF BIRTH D _____ M _____ Y _____
MOTHER'S NAME _____	PHONE (H) _____
FATHER'S NAME _____	(other) _____
ADDRESS _____	
CITY _____	POSTAL CODE _____
EMAIL _____	
DOCTOR'S NAME _____	PHONE _____
Permission to consult with your child's doctor regarding his/her condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	

- Reason for treatment:

---

---

- Date of onset:

---

---

- Symptoms:

---

---

- Has this condition occurred before?

No  Yes \_\_\_\_\_

- Are you taking any medication for any condition?

No  Yes \_\_\_\_\_

- Are you currently seeing another practitioner regarding this condition or your general health?

No  Yes \_\_\_\_\_

**HISTORY OF TRAUMA:** accidents, injuries, surgeries, big falls, blows to the head?

---

---

---

---

**DENTAL WORK:**

---

---

# GENERAL MEDICAL HISTORY

P = Past    C = Current

## GENERAL

- Feeding Problems \_\_\_\_\_
- Colic \_\_\_\_\_
- Recurrent ear infections \_\_\_\_\_
- Developmental delays \_\_\_\_\_
- Behavioural Problems \_\_\_\_\_
- Hyperactivity/ADD/ADHD \_\_\_\_\_
- Learning disabilities \_\_\_\_\_
- Eye motor problems \_\_\_\_\_

## HEAD & NECK:

- Head injury \_\_\_\_\_
- Headaches \_\_\_\_\_
- Migraines \_\_\_\_\_
- Jaw pain / clicking / locking \_\_\_\_\_
- Whiplash \_\_\_\_\_
- Vision Problems \_\_\_\_\_
- Ear/Hearing problems \_\_\_\_\_
- Fainting / Dizziness \_\_\_\_\_
- ringing in ears \_\_\_\_\_
- Sinus problems \_\_\_\_\_
- Other neurological conditions \_\_\_\_\_

## RESPIRATORY:

- Shortness of breath \_\_\_\_\_
- Bronchitis \_\_\_\_\_
- Asthma \_\_\_\_\_

## GASTROINTESTINAL:

- Nausea \_\_\_\_\_
- Gas \_\_\_\_\_
- Constipation/Diarrhea \_\_\_\_\_

## CARDIOVASCULAR:

- Heart condition \_\_\_\_\_
- High/Low Blood pressure \_\_\_\_\_
- Pacemaker etc. \_\_\_\_\_
- Cardiovascular aneurysm \_\_\_\_\_

## OTHER:

- Dislocations \_\_\_\_\_
- Fracture \_\_\_\_\_
- Spinal injury \_\_\_\_\_
- Infections \_\_\_\_\_
- Susceptible to colds/illness \_\_\_\_\_
- Insomnia \_\_\_\_\_
- Fatigue \_\_\_\_\_
- Skin conditions \_\_\_\_\_
- Cancer \_\_\_\_\_
- Epilepsy / Seizures \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Hepatitis \_\_\_\_\_
- Kidney condition \_\_\_\_\_
- Contagious condition \_\_\_\_\_
- Other \_\_\_\_\_

• Birth Story \_\_\_\_\_

• Daily Cycles:

Activity level:	none/low	moderate	high
Level of Agitation:	none/low	moderate	severe
Sleep quality:	_____		
Eating patterns:	_____		

• Is there anything else that your therapist should know?

**If you are unable to keep your appointment, please notify me at least 24 hours in advance.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_