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? ❒Yes ❒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_____