ALISO FAMILY CHIROPRACTIC

Kathy Wang, D.C. Ryan P. Clark, D.C.

11 Mareblu, Ste. 230, Aliso Viejo, CA 92656 • (949) 643-5030 • alisofamilychiropractic.com

Child's Case History

Child's Name:_____ DOB:_____ Sex:____
Parent's/Guardian's Names:_____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (___)_____ Email: _____

What is your child's chief complaint today? _____
_____
When did your child's symptoms start? _____
Have they had this problem in the past?: ( ) Yes ( ) No If so, explain: _____
_____
What aggravates their condition? _____
What provides them with relief (if any)? _____
Is this condition getting progressively worse? ( ) Yes ( ) No ( ) Same
Have they seen any other doctors for this condition? _____
Have they ever been treated by a chiropractor before? ( ) Yes ( ) No

Baby's History
Was your baby breastfed? ( ) Yes ( ) No How long? _____
Does your baby favor one breast over the other? ( ) Yes ( ) No
Does your baby have any of the following:

- ☐ Colic
- ☐ Reflux (projectile or spit up)
- ☐ Head rotated and/or tilted to one preferred side
- ☐ Difficulty latching
- ☐ Trouble sleeping
- ☐ Crying more than usual
- ☐ Allergies to:_____

Is your baby taking any medications? ( ) Yes which ones _____ ( ) No
Did your baby receive any vaccinations? ( ) Yes ( ) No

Mother's History
Did you have any problems during pregnancy? ( ) Yes ( ) No If so, explain: _____
_____
Baby was born at how many weeks? _____
Born vaginally ( ) or by cesarean ( )?
How many other children do you have? _____
How long was your labor? _____
Were you artificially induced? ( ) Yes ( ) No
Did you have an epidural? ( ) Yes ( ) No
Did you have any complications after delivering? ( ) Yes ( ) No

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Child's History

Child crawling? ( ) Yes ( ) No If so, at what age? _____
Child walking? ( ) Yes ( ) No If so, at what age? _____
Did you notice anything unusual about the child's efforts when learning to walk?
( ) Yes ( ) No If so, explain: _____
Did your child have any particularly hard falls that you recall? ( ) Yes ( ) No
If so, explain: _____
Does your child have any of the following:

- ☐ Ear infections
- ☐ Sinus trouble
- ☐ Digestive issues
- ☐ Attention issues
- ☐ Irritability
- ☐ Trouble sleeping
- ☐ Allergies to: _____
- ☐ Pain location_____
- ☐ Previous fractures explain:_____

Is your child taking any medications? ( ) Yes which ones _____ ( ) No
Did your child receive any vaccinations? ( ) Yes ( ) No
Has your child been diagnosed with any diseases? ( ) Yes ( ) No If so, explain: _____
_____

CONSENT TO TREATMENT OF MINOR

I (We) being the parent or guardian of _____, a minor, the age of _____ do hereby consent Dr. Wang or Dr. Clark to administer such treatment deemed advisable, necessary or requested on the above minor.

I (We) agree to hold him/her free and harmless from any claims, suits for damages or complications which may result from such treatment.

Parent/Guardian Name (please print) _____
Relationship to Patient: ( ) Parent/Guardian ( ) Other _____

Parent/Guardian Signature _____
Date:_____

Witness:_____