

Potomac Valley Chiropractic
12105 Darnestown Road, Suite L-8
Gaithersburg, MD 20878

Pediatric Case History

Child's Name: _____ Mother's Name: _____
Address: _____ Father's Name: _____
City: _____ State: _____ Zip Code: _____ Home #: _____
Mother's Work/Cell# _____ Father's Work/Cell#: _____

Birth Date: _____ Current Weight: _____ Current Height: _____

Type of Birth: _____ Normal Vaginal _____ Forceps _____ Breech _____ Cesarean

Any problems during the pregnancy? _____

Any problems during labor/delivery? _____

Was there presence at birth of: _____ Jaundice (Yellow) _____ Cyanosis (Blue)

Congenital Anomalies/Defects? _____

Infant Feeding: _____ Breast _____ Bottle _____ Formula

Number of hours of sleep per night: _____ Quality of Sleep: _____ Good _____ Fair _____ Poor

Please describe any problems during pregnancy. If normal, please write "normal." _____

Delivery/Birth History: _____

Developmental History

Please check any delayed milestones:
_____ Respond to sound _____ Follow an object with his/her eyes _____ Hold head up
_____ Sit alone _____ Crawl _____ Stand _____ Walk

Childhood Diseases:
_____ Chicken Pox _____ Rubella _____ Mumps _____ Measles
_____ Whooping Cough Other: _____

Please check any of the following symptoms your child has experienced:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Backaches | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Chronic Earaches |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Colds/Flu |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Constipation | <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Muscle Jerking |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Ruptures/Hernias |
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> "Growing Pains" | <input type="checkbox"/> Joint Problems |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Other: _____ | |

Please list any significant illness or medical conditions that the patient is currently being treated for.

Allergies: _____

Surgeries: _____

Medications: _____

Accidents: _____

Relevant Family History: _____

Pediatrician/Family M.D. _____ Located At: _____

Date of Last Visit to M.D. _____ Purpose: _____

Immunization History: _____

Purpose of this Appointment: _____

Insurance Billing Information: _____ Policy: _____

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary on my son/daughter/ward upon approval of parent or guardian.

Signature: _____ Witness: _____ Date: _____

I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed.

Signature: _____ Date: _____