

PEDIATRIC CASE HISTORY

*Please answer the following questions to the best of your ability.
We wouldn't ask the questions if the answers weren't important!*

Child's Name: _____ Age: _____ Nickname: _____

Mom's Name: _____ Dad's Name: _____

Your Visit Today:

Primary Reason For Today's Visit: _____

When Did the Problem Begin: _____ How: _____

Since the condition began, is it: Getting Worse Getting Better Staying the Same

Have you sought any treatment for this condition?: _____

What brings your child relief: _____

What makes the condition worse: _____

Has this affected your child's: Attendance at school Home Life Sports/Hobbies

Other: _____

Questions about Pregnancy, and Delivery:

Were there any complications during pregnancy?: No Yes If yes, please describe: _____

During pregnancy, did Mom:

Have ultrasound exams?: No Yes If yes, how many: _____

Take any medications?: No Yes If yes, please describe: _____

Consume alcohol?: No Yes If yes, please describe: _____

Smoke tobacco / other?: No Yes If yes, please describe: _____

Ingest "street drugs"?: No Yes If yes, please describe: _____

Did Mom carry to full term?: Yes No If no, how many weeks gestation was Baby: _____

Did you deliver at the hospital?: Yes No If no, where was Baby delivered?: _____

What type of care provider did you use?: OB/GYN Midwife None

Was baby delivered: Vaginally Cesarean With Forceps With Vacuum Extraction

Was the birth induced?: No Yes If yes, at what point: _____ Why: _____

Was the birth difficult?: No Yes If yes, please describe: _____

Were pain medications used? No Yes If yes, please describe: _____

Was baby breastfed?: No Yes If yes, for how long: _____

Other Questions:

Please list any medications your child is taking: _____

Please describe any hospital visits your child has had: _____

Please list any vaccinations your child has had to date: _____

Please describe any reactions to these vaccinations: _____

As a baby / toddler / little one (Infancy thru 4 years of age) did any of the following occur?:

(Studies show at least 50% of all children have fallen from a bed or other elevated surface, please be honest!!)

- | | |
|--|---|
| ◇ Fall from a bed / changing table / out of the crib | ◇ Frequent crying spells / Colic |
| ◇ Fall down stairs or off playground equipment | ◇ Frequent fevers |
| ◇ Play on a trampoline or similar equipment | ◇ Frequent ear infections or colds |
| ◇ Involvement in a car accident (even a minor one) | ◇ Frequent spitting up / gastric reflux |
| ◇ Reaction(s) to any vaccinations | ◇ Diarrhea / Constipation |
| ◇ Sleeping problems | ◇ Other: _____ |

Please explain anything you have checked off: _____

As a young child (5 thru 12 years of age) did any of the following occur?:

- | | |
|--|---|
| ◇ Fall from a tree, down stairs, playground equipment | ◇ Allergies / Allergies |
| ◇ Fall while using bicycle, rollerblades, heellies, etc. | ◇ Frequent ear infections or colds |
| ◇ Play on a trampoline or similar equipment | ◇ Frequent stomach aches |
| ◇ Injury while playing sports, or in gym class | ◇ Bed Wetting |
| ◇ Involvement in a car accident (even a minor one) | ◇ Diagnosis of Autism, or Hyperactivity |
| ◇ Diagnosis of Scoliosis | ◇ Diagnosis of Learning Disorder(s) |
| ◇ Complaints of body aches and/or pains | ◇ Other: _____ |

Please explain anything you have checked off: _____

As a child or adolescent has your child experienced any of the following?:

- | | |
|--|---------------------------|
| ◇ Headaches / Migraines | ◇ Dizziness |
| ◇ Neck Pain / Stiffness | ◇ Allergies / Asthma |
| ◇ Mid or Lower Back Pain / Stiffness | ◇ Stomach Problems |
| ◇ Growing pains | ◇ Weight Gain / Loss |
| ◇ Arm / wrist / hand / leg / ankle / foot pain | ◇ Hyperactivity / Fatigue |
| ◇ Arm / hand / leg / foot numbness | ◇ Sleeping Problems |
| ◇ Other: _____ | |

Please explain anything you have checked off: _____

Is there anything else you would like to discuss with the Doctor?: _____

Parent / Guardian Signature: _____