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PEDIATRIC CONFIDENTIAL CASE HISTORY

Child's Name:_____________________________________ Birth Date: _______________ Today's Date_________________
School: ____Grade: ______________
Person(s) completing this form: ____Phone#: __________________________
Address:____
Physican:____

How was your child referred to our clinic? ____
Current diagnosis: ____
How can we best help your child and your family?____
____
Siblings and ages: ____

Significant medical history (check all that apply):

____ ear infections
____ tubes in ears
____ headaches
____ asthma
____ ringing in ears
____ high fevers
____ breathing difficulties
____ cold feet
____ heart ailments
____ respiratory allergies
____ sinus trouble

____ seizures
____ lights bother eyes
____ sleeping problems
____ cold hands
____ dizziness
____ wearing glasses
____ bladder trouble
____ loss of balance

____ inner tension
____ irritability
____ colic

____ feeding difficulties
____ constipation
____ reflux / GI issues
____ food allergies
____ nervous stomach

____ shooting head pains
____ tightness in throat
____ muscle spasms in neck

Details of areas checked above: ____
____
____

Present symptoms (child's major complaint):____
____
____

When did you first notice major complaints?____

Minor complaints (other areas of concern): ____
____

What brought symptoms on?____
What activities aggravate the condition?____
____

Is this condition interfering with child's school:________________ sleep_______________ daily routine _______________
What do you believe is wrong with child?____

____

What have you done to get relief?____

____

List medications and supplements: ____

____

Past History:

Has child had similar problems before?______________ If yes, when?_______________________________________

What caused the episodes?_______________________ What relieved them?_________________________________

Does issue prevent child from going to school?___________Hospitalize child?____________Disable child?___________

Prior diagnosis: ____

Prior treatments for condition: ____

Name of physicians/practitioners/therapists who have treated child for this issue: ___________________________

____

____

Has child ever:

	Yes	No	Describe briefly:
Had any operations?	_____	_____	______________________________________
Broken any bones?	_____	_____	______________________________________
Been in an accident?	_____	_____	______________________________________
Had whiplash?	_____	_____	______________________________________

Does your child attend school? ______________ Number of hours in classroom per week______________________

Does your child attend daycare? _____________ Number of hours in daycare per week _______________________

Any other medical or health issues: ____

____

____

____

Patient /Guardian Signature:____ Date:___________________________