Life Chiropractic of the South Bay
Drs. Donna and Dominique Scott
510 N. Prospect Ave. Ste 207
Redondo Beach, CA 90277
310-376-5433

Pediatric Chiropractic Case History

Date: ___/___/___ No._____

Patient Name_____ Birth-date ___/___/___

Address _____

City/State _____ Zip _____ Home Phone _____

Names of Parents or Guardians: _____

_____

Phone of Parent or Guardian: Home:_____Cell: _____ Work:_____

Email:_____

How were you referred to our office? _____

Age_____ **Sex:** Male Female **Height**_____ **Weight**_____ **Handedness**: Right Left Ambidextrous

Name of Sibling: _____ Gender: _____ Age Of Sibling: _____

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Name of Sibling: _____ Gender: _____ Age Of Sibling: _____

_____

Present M.D. and City _____

Date of last M.D. visit: ____/____/____ Reason: _____

Previous D.C. and City _____

Date of last D.C. visit: _____/____/____ Reason: _____

Authorization for Care of a Minor

I hereby authorize ___Dr. Dominique Scott___and his staff to administer care as they deem necessary to my son/daughter.

Signed:_____

Witnessed:_____

Dated this _____ day of _____, 20___.

Chief Complaint

The reason you contacted us is _____

_____

Date of onset:_____/_____/_____ Onset was : Sudden Gradual

Duration of (problem) (episode) _____ Min. Hrs. Days Months Years

Pattern of (problem) Constant Intermittent Occasional

Initiating factors: _____

Exacerbating factors: _____

Diminishing factors: _____

List all therapies or treatment undergone for this complaint (including medication): _____

_____

Any concern with body function and daily activities: _____

_____

Any impacts or stresses of any kind child has been through? _____

_____

(Insurance companies only accept charges when chiropractic care for "musculo-skeletal conditions or injuries")

Any other injuries/health issues: _____

_____

Prenatal History

Duration of gestation: _____weeks. Pregnancy normal? Yes No

List any complications during pregnancy: _____

_____

Position(s) of baby during pregnancy, if known: _____

List any complications of delivery: _____

Did mother have back pain during birth? Yes No What was the position of baby at birth? face up / face down

List any medication used during pregnancy: _____

List any medication used during delivery: _____

Place of birth: Home Hospital Birthing Center Vacuum extraction? Yes No Forceps used for delivery? Yes No

Apgar score at birth:_____ Apgar score at 5 min.:_____ Weight at birth: _____ Length at birth _____

Medication History

Antibiotics? Yes No How many? _____ Most recent _____

Other medications to treat what (how often each)? _____

_____

Vaccinations taken? _____

Developmental History

Was the infant alert and responsive within twelve hours of delivery? Yes No

If "No", please explain: _____

_____

At what age did the child:

Respond to sound: _____ Sit alone: _____ Follow an object with his/her eyes: _____

Hold head up: _____ Crawl: _____ Stand:_____ Walk alone: _____

Nutritional History

Breastfed: _____months Formula began age _____ for _____months Type of formula used: _____

Cow's milk began at age _____ Other milk types & began age _____

Began solid food at age _____ months Commercially prepared baby foods used? Yes No

Type :_____

Food/Juice Intolerance or allergies? Yes No Type: _____

Social Behavior

Seems normal for age: Yes No If "No", please explain: _____

_____

_____

Childhood Diseases

Has your child had any typical childhood illness? (measles, mumps, chicken pox, whooping cough, strep, bronchitis, pneumonia) _____

_____

Other Significant Data

List any significant family history: _____

_____

_____