Nicolai Chiropractic Center – Birth to 6 year Case History

PLEASE PRINT *Use Legal Names – no nicknames* Date: _____

Child's Name: _____ Social Security #: _____
Last First Middle

Father's Name: _____ Social Security #: _____
Last First Middle

Mother's Name: _____ Social Security #: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____

HOME PHONE: _____ MOTHER'S CELL: _____ FATHER'S CELL: _____

Mother's Employer & Address: _____ Work Phone: _____

Father's Employer & Address: _____ Work Phone: _____

Insurance: _____ Policy #: _____ Name On Card: _____

Insurance: _____ Policy #: _____ Name On Card: _____

Insurance Policy Holders Date of Birth_____

Birth Date: _____ Age: _____ Gender: _____ Birth Weight: _____ Current Weight: _____

Birth Length: _____ Current Length: _____ # of Siblings: _____

Circle Type of Birth: Normal Vaginal Forceps Breech Cesarean Vacuum Extraction

Circle Place of Birth: Home Birthing Center Hospital

Was delivery long? Y/N Was delivery difficult? Y/N Was labor induced? Y/N Epidural? Y/N Pain Medication? Y/N

Problems During Pregnancy: _____

Problems During Labor/Delivery: _____

Apgar Scores: _____ At birth was there: Jaundice (yellow)? Y/N Cyanosis (blue)? Y/N

Congenital Anomalies/Defects: _____

Infant Feeding: Breast Bottle Formula Hours of sleep per night? _____ Quality of sleep: Good Fair Poor

Pediatrician/Family MD: _____ Location: _____

Last visit to MD: _____ Purpose: _____

Immunization History: _____

Reason for consulting our office: _____ Prior Chiropractic care? Y/N

Any Emergency medical treatments? Y/N Describe: _____

_____

List any falls or accidents: _____

Any surgeries? _____

Pregnancy History: _____

Delivery/Birth History: _____

Present Health History: _____

_____

OVER PLEASE

Family History: _____
How many rounds of antibiotics have been taken in the last 6 months? _____
Present medications: _____
_____

Past medications: _____

At What Age did the Child: _____ Respond to Sound _____ Crawl _____ Walk Alone
_____ Follow an object with his/her eyes _____ Stand _____Hold head up _____Walk Alone
_____ Sit Alone

Diseases: _____Chicken Pox _____ Rubella _____Rheumatic Fever _____Mumps
_____ Rubeola _____ Whooping Cough _____ Measles _____Tuberculosis _____ Other

Has this child ever suffered from: _____ Dizziness _____ Diabetes _____ Arthritis
_____ Neuritis _____ Anemia _____ Poor Appetite _____ Bed Wetting
_____ Fainting _____ Neck Problems _____ Joint Problems _____ Backaches
_____Headaches _____ "Growing Pains" _____Nosebleeds _____ Colic _____ Hyperactivity
_____ Convulsions _____Walking Problems _____ Arm Problems _____ Blood Disorders
_____ Heart Trouble _____ Hypertension _____ Asthma _____ Sinus Trouble _____ Paralysis
_____ Orthopedic Problems _____ Sugar Concentration _____ Broken Bones _____ Leg Problems
_____ Stomach Aches _____Chronic Earaches _____ Colds/Flu _____ Allergies
_____Constipation _____ Diarrhea _____Behavioral Problems _____Muscle Jerking
_____ Ruptures/Hernias _____ Other

AUTHORIZATION FOR CARE OF MINOR CHILD*RELEASE OF INFORMATION

I hereby authorize this clinic and its doctors to administer care as they so deem necessary to my Son/Daughter/Ward (upon approval of parent or guardian).

I authorize the release of information from the patient's records to doctors, hospitals, or others for continuous care and to any third party who requires information to fulfill an obligation benefitting the patient. I authorize payment to Nicolai Chiropractic from the patient's insurance company(s) and/or Medicare.

Nicolai Chiropractic Center will process insurance claims. However, I realize that I am responsible for all the charges incurred during treatment. X-rays remain property of this clinic.

Signed: _____ Date: _____
Parent or Legal Guardian

Nicolai Chiropractic Center
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