

CHILD CASE HISTORY

Date / /

Personal Data

Name _____ SS# _____ Birthday / /
Address _____ Home Phone _____ Parent cell _____
City _____ State _____ Zip _____ Parent wk _____
Parent name(s) _____ Age of Siblings _____
Parent Email(s) _____

Who referred you to our office? _____

Please check any of the following statements that describe(s) your current goals for your child's health and well being:

- I am only concerned about relief of a particular symptom.
- I am concerned about relief of a particular symptom, and preventing its return.
- I want my child to perform at the highest capacity.

CAUSE

The human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. The healthy function of every cell, every system, and every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system.

From the birth process until the present, events have occurred in your child's life which may have caused interference and damage to this delicate system. Physical, emotional, and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex.

This form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of your nervous system and therefore impair your inborn health and wellbeing.

The Vertebral Subluxation Assessment

1. **Has your child checked by a Doctor fo Chiropractic? When? _____ How long? _____**
Chiropractor's name _____ Why did you discontinue care? _____
Were x-rays taken? _____ Who is your regular pediatrician? _____
2. **Experts around the world agree: the birth process as we know it may cause extensive neurological trauma, damage, and even death to the infant.**
 - Did you have ultrasound during this pregnancy? _____ Frequency _____
 - Place of birth: Home/Birthing Center/Hospital
 - Provider: Midwife/ OB-Gyn/ Other _____
 - Type of Birth: Vaginal / C-section. Was Anesthesia used? _____ Type: _____
 - Was labor induced? _____ If yes, why? _____
 - What position did you deliver in? Squatting/ On Back / Other _____
 - Birth Trauma: Doctor Assisted / Twisting, Pulling / Vacuum Extraction/ Forceps
 - Newborn trauma (medical procedures and tests) _____
3. **Repeated studies are now informing us breast-feeding helps to develop strong and healthy immune, neurological, and digestive systems.**

Did you breast feed your child? ____ yes ____ no. How long?
Was your decision supported by your health care provider? ____ yes ____ no.
Was your decision supported by your family? ____ yes ____ no.



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4. According to the National Safety Council, approximately 50% of infants have fallen onto their heads during their first years of life. Another study reveals 1/4 million children are injured on playgrounds annually.

Can you recall any such jolts, falls or traumas to your child? ____ yes ____ no

Please describe: _____

5. Which sports does your child play? Soccer/ Football/ Gymnastics/ Karate/ Hockey/ Lacrosse/ Basketball/ Dance/ Wrestling/ Baseball/ Sensory Integration Therapy?

6. Other than the 5 hours per day spent sitting in the classroom, does your child spend additional prolonged time sitting? ____ yes ____ no. Is it in front of a computer, game, or TV?

7. How would you rate your child's diet? _____

Does your child consume artificial sweeteners? _____ Fluoridated water? _____

8. Circle any of the following your child has suffered from:

Colic, Irregular Sleeping Patterns, Night Terrors, Seizures, Tantrums, Ear Infections, Allergies, Asthma, Headaches, Poor Digestion, Repeated Infections or Colds, Toe Walking, Repeated Ankle Sprains, Walking With One Foot Turned Out, Bed Wetting, Learning Disorders, Emotional Disorders, ADD or ADHD, Sensory Processing Challenges, Other _____

9. How often has your child been treated with drugs? _____

Were you informed of their adverse reactions and side effects? _____

If it was an antibiotic, was your child cultured for its use? ____ yes ____ no

Is your child currently on any medications? (please list) _____

Any surgeries? _____

10. The child's immune system, like all other developing systems of the body, is both intricate and delicate. It strives for a state of homeostasis and balance in the body. Long term adverse effects, from interfering with this process with artificial immunizations, are just being uncovered.

Were you adequately informed of the risks of vaccinating your child? ____ yes ____ no

Did your child experience any behavioral, emotional or physical changes within 3 months after any shots?

____ yes ____ no. Describe _____

Was it reported by you or your doctor? ____ yes ____ no.

On a scale of 1-10, with 10 being optimum, how would you rate your child's current health? _____

If his or her health does not rate a 10, how likely is it that it will reach a 10 in the foreseeable future? _____

What other health care is your child receiving?

I hereby authorize Lisa Geiger, D.C. and whomever she may designate as assistants to administer chiropractic adjustments and treatment to my minor son/daughter _____.

The patient information given is true and complete to the best of my knowledge.

I understand that all services are to be paid in full at the time of the service, unless other arrangements have been made and agreed upon in writing.

Relationship to child: _____.

Parent/guardian signature

Date

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Child's Name: _____

Date: _____

Please note any **current or former** health problems of you or a family member.

Condition	Self Age ()	Father Age ()	Mother Age ()	Spouse Age ()	Brother(s) Age ()	Sister(s) Age ()	Children Age ()
Allergies							
Anxiety/Panic							
Arthritis							
Asthma							
Autism/PDD/ADHD							
Back Trouble							
Blood Pressure H/L							
Cancer							
Carpal Tunnel Synd.							
Constipation/Diarrhea							
Constant Colds							
Diabetes							
Disc Problems							
Ear Infections							
Emphysema							
Epilepsy							
Headaches/Migraine							
Heart Trouble							
Kidney Trouble							
Liver Trouble							
Neuritis							
Pinched Nerve							
Sciatica							
Scoliosis							
Sinus Trouble							
Sleep Problems							
Tinnitus							
Torticollis/Wry Neck							
Urinary Tract Inf.							
Other							
Other							

List any of the above family members that are deceased. Please include their age at death and cause:

The above information is accurate and complete, to my knowledge at this time.

Parent Signature

Date