## CASE HISTORY – PEDIATRIC VERSION (age 0-2 years)

***THE IMPORTANCE OF THIS EXAMINATION*** **DATE:** ____________________

It is a pleasure to welcome you to Victoria Family Chiropractic. **The fee for today's examination is $50** (unless special arrangements have been previously discussed). The purpose of today's visit is to provide a complete physical and neurological examination for you child to find the cause of their concern. **Except in EXCEPTIONAL circumstances no adjustments will be performed** until the file has been carefully analyzed. This approach is consistent with any significant health-related procedure. We will not compromise YOUR HEALTH or OUR REPUTATION.

Care Card PHN# ______________ Last Name ____________________ First Name _________________

Birth Date (M/D/Y) ________________ Age __________ (in months) Female __________ Male ____________

Address ____________________________________ City __________________Postal Code ______________

Name of Parents ______________________________________________________________

Parents' Home Phone _________________ Other Phone wk/cell _______________ Email ________________

Names and ages of siblings ______________________________________________________

How did you find out about our office? __________________________________________

***The human body is designed to be healthy. The primary system in the body that coordinates health is the nervous system – often called the "Master System". Beginning with the birth process until the present, events may have happened in your child's life to cause interference and damage to this master system. This form will help reveal these events and direct the doctor in performing the most appropriate examination and subsequent adjustments to help restore your child to optimum function.***

## PURPOSE OF TODAY'S VISIT

**Because chiropractic focuses on function and not disease, your child (and the rest of your family) does not need to have symptoms to benefit from care. Please indicate the reason for your child's visit today:**

1. _______ Spinal screening and wellness check
2. _______ Accident or fall. Please describe ____________________________________________
3. _______ Illness or other health problem. Please describe _______________________________

Have other doctors/therapists been consulted for this condition? **Yes** _____ **No** ______ __________________

## CURRENT AND PAST HEALTH HISTORY

1. **Doctors of Chiropractic are the only doctors trained to detect and correct vertebral subluxations (abnormally functioning spinal joints).**

Has your child ever been checked by a Doctor of Chiropractic? **Yes** ____ **No** ____ Date of last visit __________
Would you rate your experience as positive, negative or neutral? ____________ Why? ______________________

2. **According to the National Safety Council approximately 50% of infants have fallen onto their heads in the first year of life. Another study reveals that 250,000 children are injured yearly in playgrounds.**

Can you recall any such jolts, falls or traumas to your child? **Yes** ____ **No** ____
Please describe ______________________________________________________________

3. **Experts around the world agree that the birth process as we know it may cause extensive neurological trauma, damage and even death. Please circle where applicable.**

- Did Mother have ultrasound during the pregnancy? **Yes** ____ **No** ____ If yes, how many & why? _____
- Did Mother smoke or drink alcohol during pregnancy? **Yes** ____ **No** ____
- Place of birth: Home/ Birthing Centre/ Hospital/ Other _________________________
- Provider: Midwife/ Ob-Gyn/ Other __________________________________________
- Type of Birth: Vaginal/ C-Section (emergency or planned)/ Breech
- Was anaesthesia used? **Yes** ____ **No** ____ If yes, what type? Epidural/ IV/ Other ______________________
- Was labour induced? **Yes** ____ **No** ____ If yes, why? _____________________________________________
- What position was delivery? Squatting/ On Back/ Other ___________________________________________
- Birth Trauma: Doctor assisted/ Forceps/ Vacuum extraction/ Twisting, Pulling
- Medical Trauma: What tests and procedures were performed? (eg. Vit. K, heel prick, etc.) _______________

4. **Repeated studies are now informing us that breast-feeding develops strong and healthy immune, neurological and digestive systems.**

Was child breast fed? **Yes** ____ **No** ____ If yes, how long? ____________________________
Did you feed your child formula? **Yes** ____ **No** ____ If yes, what type? ___________________________
Has solid food been introduced? **Yes** ____ **No** ____ If yes, when ________________________________
Does your child have any food intolerances? **Yes** ____ **No** ____ If yes, what? __________________________
Does your child consume foods with caffeine or artificial sweeteners? (Aspartame, Nutrasweet) **Yes** ___ **No** ____

5. **While chiropractic does not treat disease it does reduce stress, enhance immunity and regulate the function of the master system – the nervous system. In this way many symptoms are alleviated. Please circle any of the following conditions your child has suffered from:**

Colic, Irregular Sleeping Patterns, Night Terrors, Seizures, Tantrums, Ear Infections, Allergies, Asthma, Headaches, Poor Digestion, Repeated Infections or Colds, Other __________________________________________

6. **We now know that over 90% of ear infections are due to viral infections and the use of antibiotics does nothing to shorten or reduce the infection. The indiscriminate use of antibiotics DOES however make your child more susceptible to future infections and adds to the problem of drug-resistant bacteria.**

Is your child currently taking any medications? Yes ____ No ____ Please list ____________________________
Has your child ever been prescribed antibiotics? Yes ____ No ____ How many times/ what type? ____________
Has your child ever been prescribed any other drugs? Yes ____ No ____ Please list _______________________
Were you given adequate information on the possible adverse reactions? Yes ____ No ____
Has your child had any surgery? Yes ____ No ____ Please list __________________________________________

7. **Your child's immune system, like all other developing systems, is both intricate and delicate. Given the proper environment it will naturally develop life-long immunity to most childhood diseases. The process of vaccination seeks to provide artificial immunity, which is significantly different, requires periodic boosters and may in fact be harmful to your child's health.**

Has your child been vaccinated? **Yes** ____ **No** ____ Please list __________________________________________
Were you adequately advised of the risks and benefits of each vaccine? **Yes** ____ **No** ____
Did your child experience any emotional, physical, neurological or behavioral changes within 3 months of any vaccination? **Yes** ____ **No** ____ Please describe _____________________________________________________
Was this reported by you or your Medical Doctor? **Yes** ____ **No** ____

***Thank you for taking the time to completely and accurately fill out this form. We are here to serve you and encourage you to ask questions. Should you ever have any concerns, please feel free to bring them up.***

**Congratulations on making a key choice in raising an exceptional, drug-free child!**

**Yours in Health – Dr. Cale Copeland, BSN, DC**