**Hulsebus Chiropractic Clinic**

**1010 Harlem Road • Machesney Park, IL 61115**

**815.654.1044**

**Child Case History**

**Patient Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Age) \_\_\_\_\_\_\_\_\_ Gender: M F

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Mother/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_ (Age) \_\_\_\_\_\_\_\_ Marital Status: S M D W Work Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Father/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_ /\_\_\_\_ (Age) \_\_\_\_\_\_\_\_ Marital Status: S M D W Work Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to this office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen a chiropractor before? Yes / No

**Purpose for This Visit**

Reason for this visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this related to an accident or specific injury (other than auto or work-related)\*? Yes / No If yes, when: \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_

***\*If your child’s symptoms are the result of an auto accident or work-related injury, please ask the front-desk for the corresponding application.***

Describe incident or reason for onset of symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your child’s symptoms.**

When did these symptoms begin? \_\_\_\_/ \_\_\_\_/\_\_\_\_ Are they: Constant Intermittent Activity-related

Are they getting worse? Yes / No Do they interfere with: School Sleep Hobbies/Play Daily Routine

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities aggravate these symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything that relieves your symptoms? Yes / No If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child experienced these symptoms before (if not accident/injury related)? Yes / No

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been treated for this? Yes / No When was the last treatment? \_\_\_\_/ \_\_\_\_/\_\_\_\_

Name of treating practitioner/facility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What treatment(s) was performed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did your child respond? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENERAL SYMPTOMS CHART

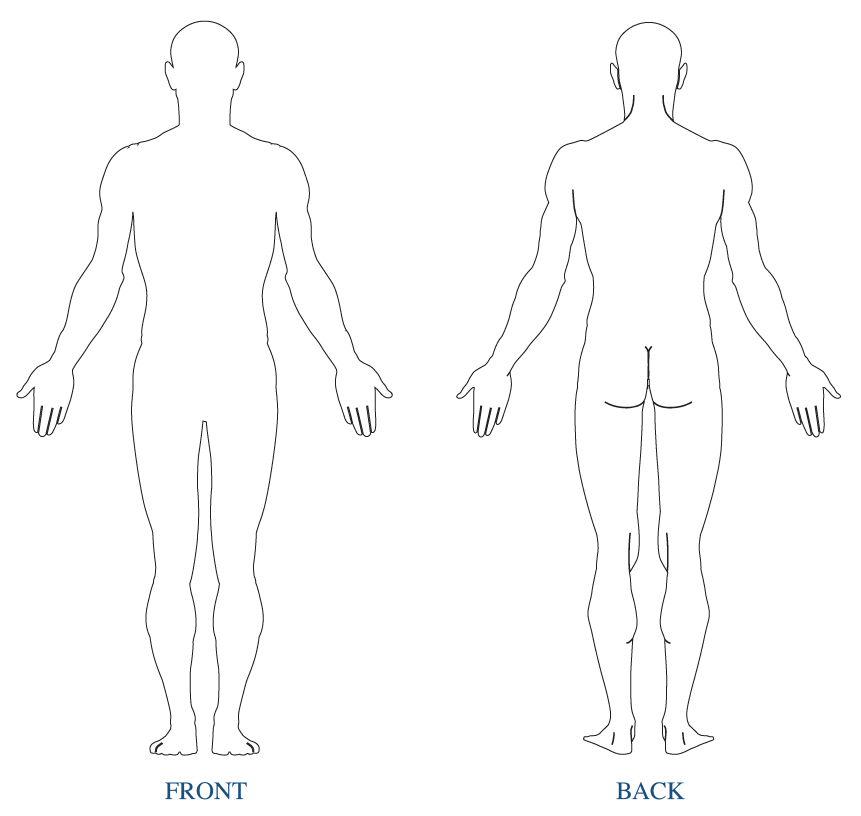
Please use the following notations on the figures below to indicate the type and location

of your symptoms, as it relates to the purpose of your visit today.

A = ACHE G = STABBING N = NUMBNESS

B = BURNING M = SPASMS T = TINGLING

P = PINS & NEEDLES F = STIFFNESS O = OTHER

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**HISTORY OF TRAUMA**

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue injury to the supportive structures of the

spine, as well as shifts and distortions in whole curves and sections of the spine. Please check any of the following if your child has

experienced such (*if you check an item with an asterisk, please offer a detailed explanation*):

\_\_\_\_ Fell from a height of two (2) feet or more as an infant

\_\_\_\_ Experienced a fall that left a bruise or lump on their head or other resulting trauma\*

\_\_\_\_ Rough shaking as an infant

\_\_\_\_ Were involved in a car accident (***if you check this item, please ask the front desk person for the corresponding form***)

\_\_\_\_ Experience broken bones or debilitating injuries\*

\_\_\_\_ Difficult Birth (see below)

Explanation of (\*) item(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birth Experience:**

How long was labor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of delivery: Vaginal C-Section Vacuum Extraction Forceps Assistance

**Health Conditions**

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread

ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.Please answer the following questions accurately so we may determine the full extent of your child’s condition.

Cervical Spine (Neck)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

***Please indicate (N) = Now, (P) = Past next to all conditions you’ve experienced or both if applicable.***

\_\_\_\_ Neck Pain \_\_\_\_ Headaches \_\_\_\_ Sinusitis

\_\_\_\_ Pain in shoulders/arms/hands \_\_\_\_ Dizziness \_\_\_\_ Allergies/Hay fever

\_\_\_\_ Numbness/tingling in arms/hands \_\_\_\_ Visual disturbances \_\_\_\_ Re-current colds/Flu

\_\_\_\_ Hearing disturbances \_\_\_\_ Coldness in hands \_\_\_\_ Low Energy/Fatigue

\_\_\_\_ Weakness in grip \_\_\_\_ Thyroid conditions \_\_\_\_ Colic

\_\_\_\_ Ear Infections \_\_\_\_ Flu/Stomach disorders \_\_\_\_ Sore throats

\_\_\_\_ Learning disabilities \_\_\_\_ Hyperactivity/ADD \_\_\_\_ Auto-Immune Diseases

\_\_\_\_ Other (please explain)

Thoracic Spine

Misalignment of the individual vertebrae or distortion of the upper thoracic curve originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced

any of these symptoms presently or in the past?

***Please indicate (N) = Now, (P) = Past next to all conditions you’ve experienced or both if applicable.***

\_\_\_\_ Heart Palpitations \_\_\_\_ Heart Murmurs \_\_\_\_ Asthma/Wheezing \_\_\_\_ Shingles

\_\_\_\_ Shortness Of Breath \_\_\_\_ Upper Back Pain \_\_\_\_ Pain On Deep Inspiration/Expiration

\_\_\_\_ Recurrent Lung Infections/Bronchitis/Pneumonia \_\_\_\_ Mid Back Pain \_\_\_\_ Nausea

\_\_\_\_ Diabetes \_\_\_\_ Pain in Ribs/Chest \_\_\_\_ Ulcers/Gastritis \_\_\_\_ Reflux

\_\_\_\_ Diabetes \_\_\_\_ Liver problems \_\_\_\_ Spleen problems \_\_\_\_ Other (please explain)

LUMBAR Spine (Low Back)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

***Please indicate (N) = Now, (P) = Past next to all conditions you’ve experienced or both if applicable.***

\_\_\_\_ Low back pain \_\_\_\_ Pain in hips/legs/feet \_\_\_\_ Weakness/injuries in hips/knees/ankles

\_\_\_\_ Numbness/tingling in legs/feet \_\_\_\_ Coldness in legs/feet \_\_\_\_ Muscle cramps in legs/feet

\_\_\_\_ Frequent/difficulty urinating \_\_\_\_ Constipation/Diarrhea \_\_\_\_ Menstrual irregularities/cramping

**OTHER**

Have you ever been hospitalized? Yes/ No

Please list any surgeries (include type of surgery and date it was performed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy Release**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. Yes / No

**Consent to Treat a Minor**

I hereby authorize the doctor and/or his designated staff to administer chiropractic care as deemed necessary to my \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (indicate relationship of child).

Name of Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dated at Machesney Park, IL on this \_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witnessed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_