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? ____

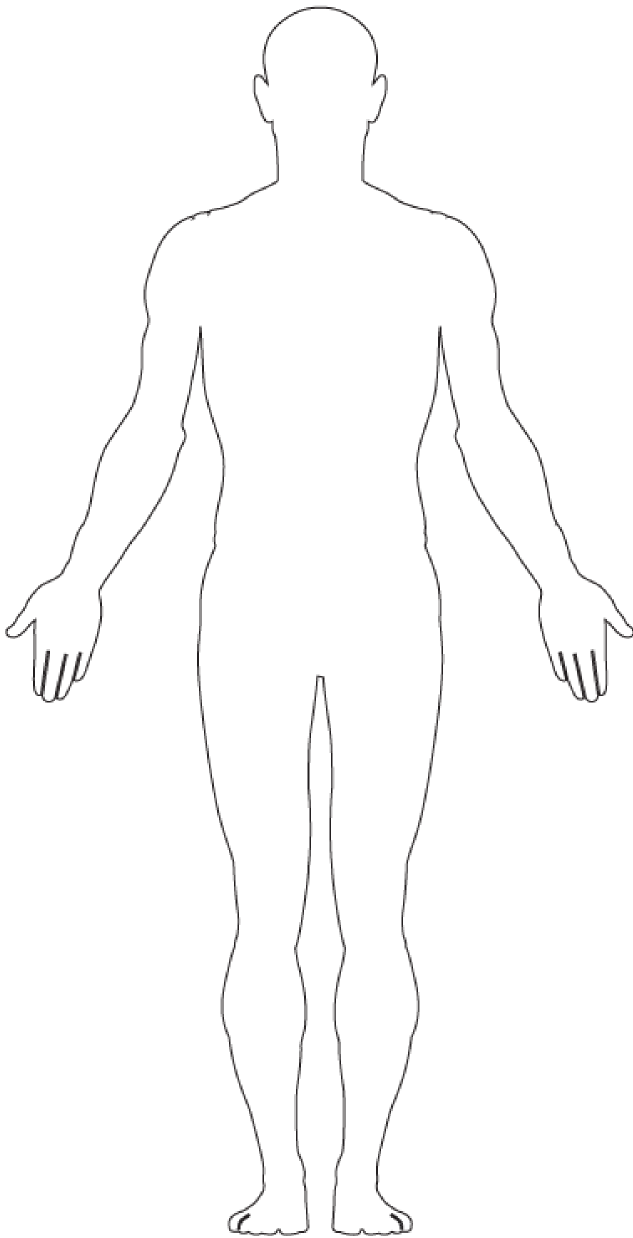
What treatment(s) was performed? ____

How did your child respond? ____

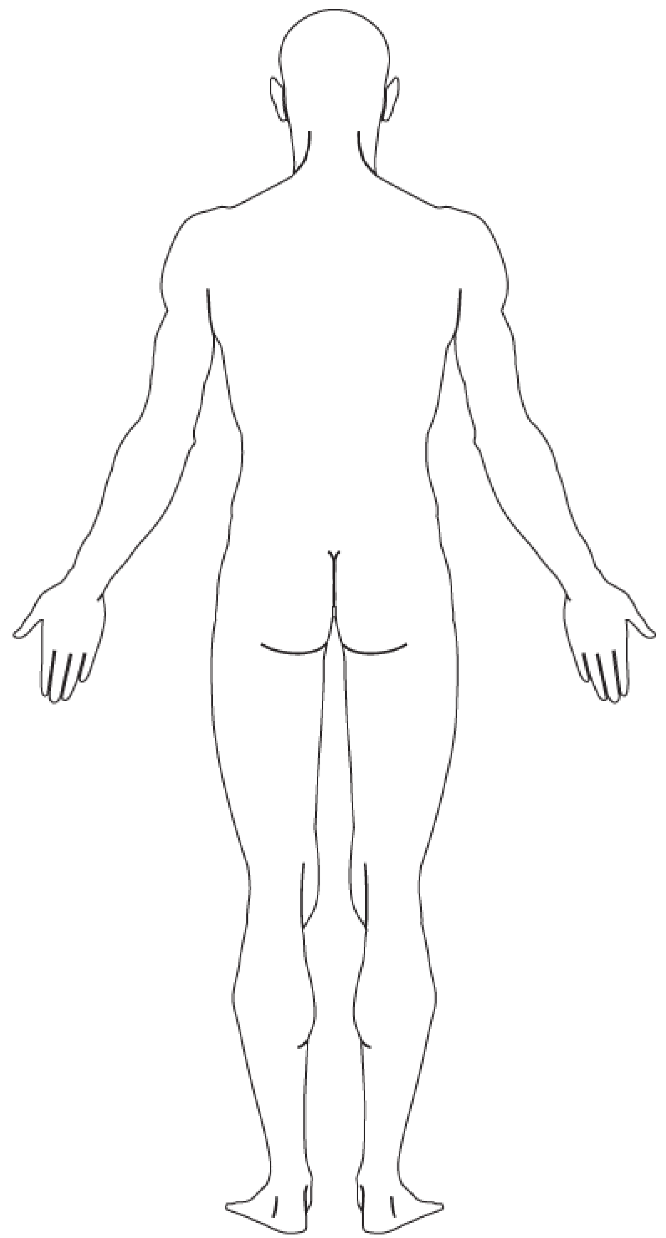
GENERAL SYMPTOMS CHART

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



FRONT



BACK

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
____ Pain in shoulders/arms/hands
____ Numbness/tingling in arms/hands
____ Hearing disturbances
____ Weakness in grip
____ Ear Infections
____ Learning disabilities
____ Other (please explain)
____ Headaches
____ Dizziness
____ Visual disturbances
____ Coldness in hands
____ Thyroid conditions
____ Flu/Stomach disorders
____ Hyperactivity/ADD
____ Sinusitis
____ Allergies/Hay fever
____ Re-current colds/Flu
____ Low Energy/Fatigue
____ Colic
____ Sore throats
____ Auto-Immune Diseases

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: ____