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

Reason for this visit: _____

Describe: _____

When did these symptoms begin? ____/____ /_____ How did your child's symptoms start? _____

Are they getting worse? Yes / No Are they: Constant Intermittent Activity-related

Do they interfere with: School Sleep Hobbies Daily Routine Pain Scale: _____ (0 being no pain-10 being worst pain)

Explain: _____

What activities aggravate your child's symptoms? _____

Is there anything that relieves your child's symptoms? _____

Has your child experienced these symptoms before? Yes/ No

If yes, explain: _____

Have you been treated for this? Yes / No When were you last treated? ____/ ____ /____

Who did you see? _____

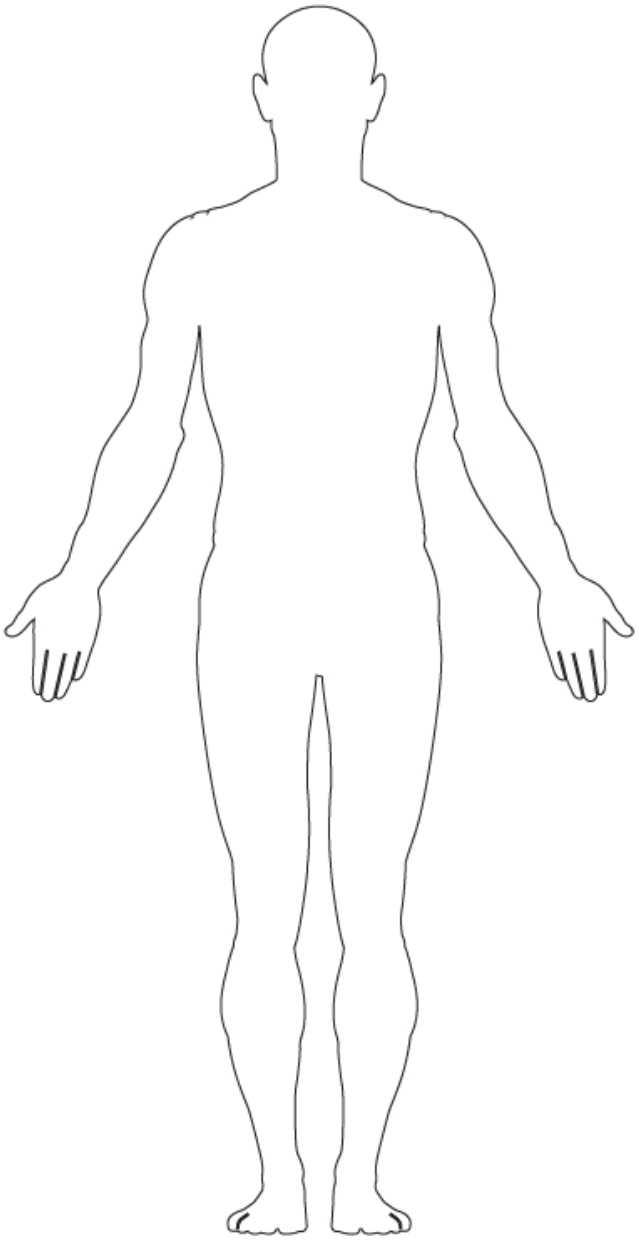
What treatment was performed? _____

How did you respond? _____

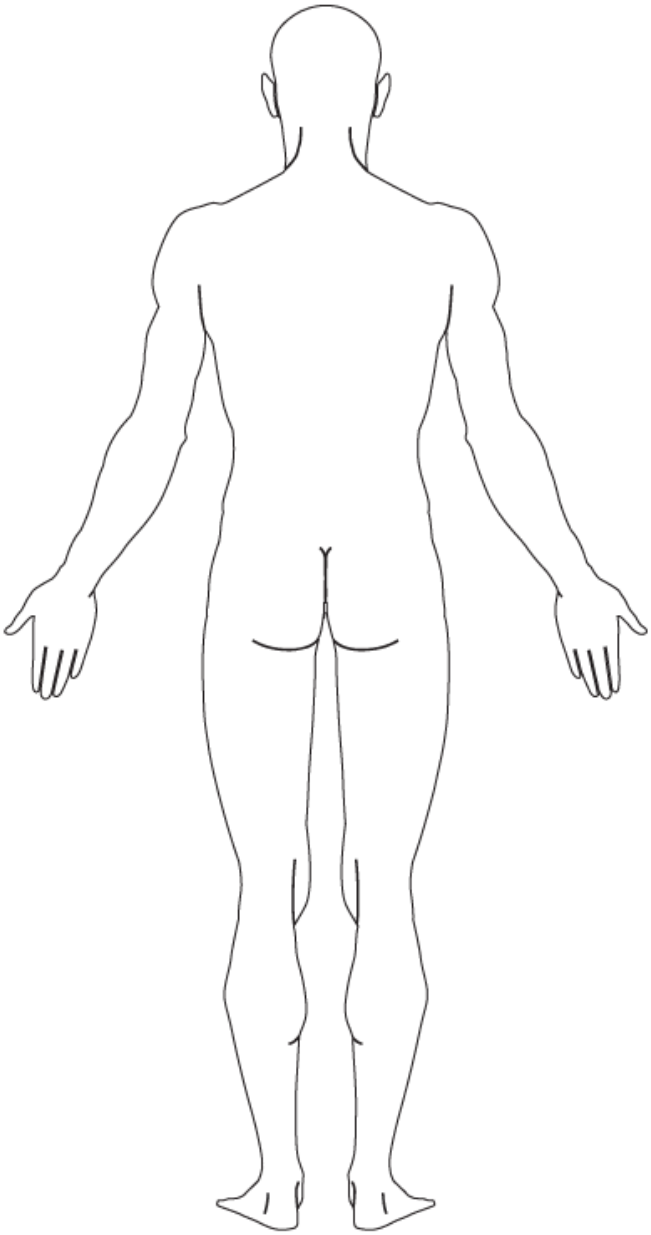
GENERAL SYMPTOMS CHART

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

Describe any complications: _____

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.

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

CERVICAL SPINE (Neck)

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

THORACIC SPINE

____ Upper Back Pain
____ Mid-Back Pain
____ Pain in Ribs/Chest
____ Reflux / Heartburn
____ Nausea
____ Heart Palpitations
____ Heart Murmurs
____ Diabetes
____ Ulcers/Gastritis
____ Shingles
____ Recurrent Lung Infections/Bronchitis/Pneumonia
____ Asthma/Wheezing
____ Shortness of Breath
____ Pain on Deep Inspiration/Expiration
____ Liver/Spleen problems

LUMBAR SPINE (Low Back)

____ Low back pain
____ Pain in legs/feet
____ Pain in hips/knees/ankles
____ Numbness/tingling in legs/feet
____Coldness in legs/feet
____ Muscle cramps in legs/feet
____ Frequent/difficulty urinating
____ Constipation/Diarrhea
____ Bed wetting

HEALTH & LIFESTYLE

Does your child take any supplements (i.e. vitamins, minerals, herbs) or Prescription Medications? Yes / No

If yes, please list: _____

_____

_____

Is your child allergic to any Medications? Yes / No If yes, please list: _____

Height: _____ Weight: _____ Blood Pressure: _____/_____

OTHER

Has your child 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: _____