Evon Chiropractic, P.C.
206 Floral Vale Blvd.
Yardley, PA 19067
Phone: 215.504.7200
Fax: 215.504.7201
evonchiro@comcast.net

Child Case History

Name____Birthdate____________Sex________

Address___________________________________City___________________Zip___________

Parents Names______________________________Phone_____________Work/Cell___________

Siblings and ages____

Who referred you to our office?____

Vertebral Subluxation Assessment

1. Has your child been checked by a Doctor of Chiropractic?________ If Yes, when__________
   Were X-rays taken?_______ Who is your 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 an ultrasound during this pregnancy?______________________________
     Frequency____
   - Place of Birth____
   - Provider____
   - Type of Birth: Vaginal/C-Section. Was anesthesia used?___________________________
     Type of anesthetic____
   - Was labor induced ?_________If Yes, Why___________________________________
   - What position did you deliver in: Squatting/ On Back
   - Birth Trauma: Doctor Assisted / Twisting Pulling / Vacuum Extraction / Forceps /
     Other____
   - Newborn Trauma (medical procedures and tests)_______________________________
     ____

3. Did you breast-feed your child?______________ For how long?______________________
   Was your decision supported by your provider? _____________________________________
   Repeated studies are now informing us breast-feeding develops strong and healthy immune, neurological and digestive systems.

According to the National Safety Council approximately 50% of infants have fallen onto their heads during their first years of life. Another study reveals ¼ million children are injured on playgrounds annually. Can you recall any such falls or trauma to your child? ______________________________

____

4. Does your child play any sports?____

5. Other than in the classroom does your child spend any prolonged time sitting?

   ____

6. How would you rate your child's diet?____

7. How often has your child been treated with drugs/antibiotics?________________________________

   ____

   Is your child currently on any medications?_______If Yes please list___________________________

   Any surgeries____

   Did your child experience any behavioral, emotional or physical changes within 3 months of having any shots or vaccinations?____

8. Circle any of the following conditions your child has suffered from: Colic, Irregular Sleep Patterns, Night Terrors, Seizures, Tantrums, Ear Infections, Allergies, Asthma, Headaches, Poor Digestion, Repeated Colds or Infections, Bed Wetting, Learning Disorders, Emotional Disorders, ADD, ADHD, Other____

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Additional questions or concerns?

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Parent Signature____Date____________________