COUNTRY ROADS

Mobile Chiropractic

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Minor Case History

Patient Name: _____ Birth Date: _____ Age: _____

Sex: Male ___ Female ___ Weight: _____ Height: _____ School: _____

Address: _____ City: _____ State: _____ Zip:_____

Parent/Guardians Names: _____

1* Phone: _____ 2* Phone: _____ Email: _____

How did you hear about us? _____

Reason for seeking care: _____

When did this start? _____ Have you seen other professionals? Yes __ No __

What other treatments have you tried? _____

_____

Is this condition getting progressively Worse Better Staying the same

Health History

Name of Pediatrician: _____

Any medications/supplements? _____

Any previous injuries or accidents? _____

Surgeries: _____

Do they play any sports: _____

How many hours of screen time? _____ Caffeinated drinks? _____

Follow a specific diet? _____

Do they have, or have they ever had any of the following symptoms?

- ADHD
- Hyperactivity
- Behavioral Issues
- Sensory Issues
- Chronic Earaches
- Frequent Illness
- Headaches
- Dizziness
- Fainting
- Asthma
- Allergies
- Neuritis
- Sinus Trouble
- Cough/Wheeze
- Chest Pain
- Poor memory
- Insomnia
- Nightmares
- Bed wetting
- Painful urination
- Seizures
- Muscle Pain
- Broken bones
- Sprains/strains
- Hernias
- Neck Pain
- Back Pain
- Arm/Elbow pain
- Leg/hip pain
- Knee/Foot pain
- Growing Pains
- Joint Pain
- Scoliosis
- Digestive issues
- Constipation
- Diarrhea
- Poor appetite
- Stomach aches
- Diabetes
- Hypertension
- Hypotension
- Cancer
- Clotting Disorders
- _____
- _____

Please indicate if there is a family history of any of the following conditions.

Condition	**Relative**
Diabetes	
Cancer	
Anemia	
Hypertension	
Metabolic Disorders	
Autoimmune disorders	
Asthma	
Emphysema	

By signing below you agree that this form is filled out to the best of your ability and as accurately as possible for the patient listed at the top of the form.

_____ _____

Guardian Name Date