

Children's Case History

Child's Name _____ Birthdate _____ Sex _____

Address _____ City _____ Zip _____

Parents' Names _____

Parent's Phone _____ Work# _____

Siblings and ages _____

Who referred you to our office _____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Boufford or another person authorized by her, to administer care as deemed necessary to my son/daughter.

Signed _____ Date _____

Witnessed _____ Date _____

INSURANCE INFORMATION

Who is responsible for the account? _____ Relationship to patient _____

Insurance Company _____ Subscriber's Name _____

Contract Number _____ Subscriber's Birth date _____

Group Number _____ Subscriber's SS# _____

Is patient covered by additional insurance? _____

Insurance Company _____ Subscriber's Name _____

Contract Number _____ Subscriber's Birth date _____

Group Number _____ Subscriber's SS# _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance with _____
And assign directly to **Dr. Catherine Boufford** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

Signature of Responsible Party

Vertebral Subluxation Assessment

1. Has your child been checked by a Doctor of Chiropractic? _____ Who? _____
Were x-rays taken? _____. Who is your regular 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 ultrasound during this pregnancy? _____ Frequency _____

• Place of birth: Home/ Birthing Center/ Hospital .
• Provider: Midwife/ OB-Gyn/ Other _____

• Type of Birth: Vaginal / C-section. Was anesthesia used? _____ Type _____

• Was labor induced? _____ If yes, why? _____

• What position did you deliver in: Squatting/ On Back

• Birth Trauma: Doctor assisted/ Twisting, Pulling/ Vacuum Extraction/ Forceps

• Newborn trauma (medical procedures and nests) _____

3. Did you breast-feed your child? _____ yes _____ no. How long? _____

Was your decision supported by your health care provider? _____ yes _____ no.

Repeated studies are now informing us breast-feeding develops strong and healthy immune, neurological and digestive systems.

4. According to the National Safety Council approx. 50% of infants have fallen onto their heads during their first years of life. Another study reveals 1/4 million children are injured in playgrounds annually. Can you recall any such jolts, falls or traumas to your child? _____ Please

Describe: _____

Any fractures or dislocations? _____

5. Which sports does your child play? Soccer/ Football /Gymnastics/ Karate/ Hockey/ Lacrosse/
Basketball/ Dance/ Wrestling/ Baseball/ Other _____.

6. Other than the 5 hours per day spent sitting in the classroom, does your child spend additional prolonged time sitting? _____ yes _____ no. Is it in front of a computer or TV? _____

7. How would you rate your child's diet? _____

Does your child consume artificial sweeteners? _____

Fluoridated water? _____

8. Circle any of the following conditions your child has suffered from :

Colic, Irregular Sleeping Patterns, Night Terrors, Seizures, Tantrums, Ear Infections, Allergies, Asthma, Headaches, Poor Digestion, Repeated Infections or Colds, Bed Wetting, Learning Disorders, Emotional Disorders, ADD or ADHD, Other

9. How often has your child been treated with drugs ? _____

Were you informed of their adverse reactions ? _____ yes _____ no

If it was an antibiotic, was your child cultured for its use? _____

Is your child currently on any medications? (please list) _____

Any surgeries? _____

10. The child's immune system, like all other developing systems of the body is both intricate and delicate.

It strives for a state of homeostasis and balance in the body. Long term, adverse effects from interfering with this process with artificial immunizations are just being uncovered. Were you adequately informed of the risks of vaccinating your child? Did your child experience any behavioral, emotional or physical changes within 3 months after any shots? _____ Describe _____
Was it reported by you or your doctor? _____

Health History:

Please give approximate dates of any motor vehicle accidents: _____

Please give approximate dates of any other serious injuries: _____

Please list all surgeries: _____

Please list all medications you are currently taking: _____

Current Symptoms (if applicable):

What is your primary reason for this visit? _____

Where specifically is the problem located? _____

How did you first notice the symptoms? _____

How did this condition begin? _____

Is this condition getting progressively worse? _____

Have you previously experienced this problem? _____

Is the pain constant or does it come and go? _____

Does the pain wake you at night? _____

Have you had any loss of bowel or bladder control? _____

Please circle the severity of your pain. Mild Moderate Severe

Are you experiencing other symptoms? Please state their location.

N=neck **MB**=mid-back pain **LB**=lower back pain **A**=arms **L**=legs
Numbness Tingling Weakness Stiffness

Have you received any medical treatment for your condition? Yes No

What type of treatment? _____

Have you ever received chiropractic care? Yes No

Who was your doctor? _____

When was your last treatment? _____