

**Clinic Name**  
**Clinic Address**  
**Clinic Phone & Fax Number**

PT ID #: \_\_\_\_\_

**Children's Case History**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(Please Print)

Child's Name: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ First Last Age: \_\_\_\_\_ Current WT & LGTH: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_ First Last

Address: \_\_\_\_\_ First Last

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Insurance Information: \_\_\_\_\_

Place of Birth: (Check one of the following)  Home  Hospital  Birthing Center  Other

Problems with Delivery or Labor: \_\_\_\_\_

Was Child Cyanotic (Blue Baby): \_\_\_\_\_ Jaundice (Yellowish) \_\_\_\_\_

Describe Birthmarks, If Any: \_\_\_\_\_

Apgar Score, If known: \_\_\_\_\_

Immunizations or Other Toxins: \_\_\_\_\_

Family History: (Check one of the following)  Retardation  Diabetes  Epilepsy  Allergies  Other:

Type of Feeding:  Breast  Bottle  Formula (Brand Name) \_\_\_\_\_

Child's Symptoms and/or Parent's Comments: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian