Dr. Marianna Fuscaldo, BSc, DC

Date _____ /_____ /_____

Child's Name _____ Mother's Name _____

Care Card # _____ Father's Name _____

Address _____ City/Province _____ Postal Code _____

Home Phone (_____) _____ Mom's Cell/work (_____) _____ Father's Cell/work (_____) _____

Birth Date _____ Age _____ Birth weight _____ Birth Length _____

Gender _____ Number of siblings _____ Current weight _____ Current length _____

Type of Birth: Vaginal without assistance _____ Foreceps _____ Breech _____ Cesarean _____ Home _____

Birthing centre _____ Hospital _____

Problems during pregnancy: _____

Problems during labour/delivery: _____

APGAR Scores _____ Was there presence at birth: Jaundice? _____ Cyanosis? _____

Congenital anomalies/deficits: _____

Infant feeding: Breast _____ Bottle _____ Formula _____ Solids (list)_____

hours sleep per night _____ Quality of sleep: Good _____ Fair _____ Poor _____

Obstetrician/Midwife: _____

Pediatrician/Family MD: _____

Date of last visit to MD: _____ Purpose: _____

Immunization history: _____

Purpose of this appointment: _____

Has your child ever been treated on an emergency basis? Y or N If yes, describe: _____

Has your child ever suffered from?

- ☐ Dizziness
- ☐ Diabetes
- ☐ Arthritis
- ☐ Neuritis
- ☐ Anemia
- ☐ Poor Appetite
- ☐ Bed wetting
- ☐ Fainting
- ☐ Joint Problems
- ☐ Other_____
- ☐ Backaches
- ☐ Tuberculosis
- ☐ Headaches
- ☐ Digestive disorders
- ☐ Rheumatic fever
- ☐ Hyperactivity
- ☐ Convulsions
- ☐ Walking problems
- ☐ Neck problems
- ☐ Heart trouble
- ☐ Hypertension
- ☐ Asthma
- ☐ Sinus troubles
- ☐ Orthopedic problems
- ☐ Behavioral problems
- ☐ Paralysis
- ☐ Broken bones
- ☐ Cancer
- ☐ Chronic earaches
- ☐ Colds/Flus
- ☐ Allergies
- ☐ Constipation
- ☐ Diarrhea
- ☐ Muscle jerking
- ☐ Growing pains
- ☐ Stomach aches
- ☐ Colic

Parent/guardian Signature _____ Date _____ / _____ / _____

Dr. Marianna Fuscaldo, BSc, DC Date _____ /_____ /_____

Pediatric Case History

Pregnancy History

_____

_____

_____

_____

_____

Delivery/Birth History

_____

_____

_____

_____

_____

Developmental History

At what age did the child: Respond to sound _____ Follow an object with their eyes _____

Hold head up _____ Sit alone _____

Crawl _____ Stand _____

Walk alone _____ Other _____

Present History

_____

_____

_____

_____

_____

Medical History

Surgeries/hospitalizations: _____

Medications/supplements: _____

Accidents: _____

Relevant family medical history: _____

_____