Andreas Chiropractic Clinic
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Pediatrics
Infants - School Aged

Child's Name: _____ Date: _____
Parents'/Guardians' Names: _____
Home Address: _____
Home Phone: _____ May we leave a message? ☐ Yes ☐ No
Parent's Cell Phone: _____ May we leave a message? ☐ Yes ☐ No
Parent's Work Phone: _____ May we leave a message? ☐ Yes ☐ No
Parent's Email: _____
How did you hear about us? _____
Height (of child): _____ Weight: _____ Birth Date: _____ Age: _____ Sex: _____
Siblings and ages: _____
Previous Chiropractic Care? ☐ Yes ☐ No

Emergency Contact
Name: _____ Relationship to child: _____
Phone number: _____ Alternative phone number: _____

Family Doctor
Name: _____ Professional Designation: _____
Clinic Name: _____ Date and reason of last visit: _____
May we communicate with your family doctor regarding your child's care if necessary? ☐ Yes ☐ No

Other Health Care Professionals
(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, OT, Massage Therapist, etc)
Name: _____ Professional Designation: _____
Clinic Name: _____ Date and reason of last visit: _____

Name: _____ Professional Designation: _____
Clinic Name: _____ Date and reason of last visit: _____

Why have you decided to have your child evaluated by a Chiropractor?
- ☐ He / She is continuing ongoing care from another chiropractor.
- ☐ I recently had my spine checked and understand the value in getting my child checked.
- ☐ I have concerns about his/her health and I'm looking for answers.
- ☐ He / She has a specific condition and I've learned that chiropractic may be able to help.
- ☐ I want to improve my child's immune function.

Wellness Profile

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called ***vertebrae***. Many of the common health challenges that adults experience have their origins during the ***developmental years***, some starting at birth. Layers of damage to the spine and ***nervous system*** occur as a result of various ***traumas, toxins, and emotional stress***. The result may be misalignment to the spinal column and damage to the nervous system - a condition called ***Vertebral Subluxation***. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's ***ability to heal***.

What signals has your child's body been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Failure to Thrive / Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Slow or Absent Reflexes
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Crawling or Gait
☐	☐	Ear Infections	☐	☐	Headaches/Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis / Head Tilt	☐	☐	Sleep Problems
☐	☐	Frequent Colds / Croup	☐	☐	Trouble Feeding on One Side	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Sensory Processing Issues
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joint	☐	☐	Tremors / Shaking
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	ADD / ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying Spells	☐	☐	Autism / PPD

Do you have a specific concern that brings you in?

☐ No, I would like my child's nervous system assessed to achieve optimal health & functioning.

☐ Yes: _____

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? _____ For how long? _____

Is it getting better, worse, or staying the same? _____ Suddenly or gradually? _____

Have you seen other health professionals regarding this complaint?

☐ No ☐ if Yes, whom? _____

What treatment did they use? _____

Has your child taken any medication for this complaint? ☐ No ☐ Yes: _____

Has your child ever experienced this complaint before? ☐ No ☐ Yes: _____

Has your child received any treatment at this time? ☐ No ☐ Yes: _____

Has your child had x-rays in relation to the current complaint? ☐ No ☐ Yes: _____

Has your child had any blood work done for the current complaint? ☐ No ☐ Yes: _____

Prenatal Profile

☐ Adopted ☐ Prenatal history unknown ☐ Birth history unknown

Complications during pregnancy: ☐ No ☐ Yes (brief description): _____

Ultrasounds during pregnancy: ☐ No ☐ Yes (brief description): _____

Medications during pregnancy: ☐ No ☐ Yes (brief description): _____

If so which ones and how often? (include OTC):

Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy:

☐ No ☐ Yes (brief description): _____

Birth Experience

Location of Birth: ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other: _____

Birth Attendants: ☐ Doula ☐ Midwife ☐ GP ☐ OB ☐ Other: _____

Medications during labor / delivery (including IV antibiotics): ☐ No ☐ Yes: _____

Was Pitocin used to induce / speed up labor? ☐ No ☐ Yes

Were your membranes ruptured by a medical professional? ☐ No ☐ Yes

Was your child at anytime during your pregnancy in a constrained position? ☐ No ☐ Yes ☐ Unsure

If yes, please describe: ☐ Breech ☐ Transverse ☐ Face / Brow presentation

Was your delivery vaginal or C-section? _____ If C-section, was it planned or emergency? _____

If it was vaginal, was the baby presented: ☐ Head ☐ Face ☐ Breech

Were any of the following interventions used? ☐ Forceps ☐ Vacuum Extraction ☐ Other

Were there any complications during delivery? ☐ No ☐ Yes

If yes, please specify: _____

How long was the labor from the first regular contractions to the birth? _____ hours.

How long was the second stage (the pushing phase) of the labor? _____ hours.

Was the baby born with any purple markings / bruising on their face or head? ☐ No ☐ Yes

Any concerns about misshapen head at birth? ☐ No ☐ Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? _____ Weight: _____ Length: _____

If known, APGAR scores at: 1 minute: _____/10 5 minutes: _____/10

Was the baby ever administered to the NICU? ☐ No ☐ Yes

If yes, for how long and why? _____

Was any medication given to the child at birth? ☐ No ☐ Yes ☐ Unsure

If yes, what medication and why? _____

Was your child exclusively breastfed? ☐ No ☐ Yes Months: _____

Was your child breastfed + formula fed? ☐ No ☐ Yes Months: _____

Did your child show any sensitivities to formula (reflux, eczema, arching back)? ☐ No ☐ Yes

What age did you introduce solid foods to your child? _____ months

Did you introduce cereal or grains within your child's first year? ☐ No ☐ Yes

Did your child spend a lot of time in any baby devices (bouncy seats, swings, bumbos, car seats, etc)?

☐ No ☐ Yes Which ones? _____

Physical Traumas

Has your child ever fallen from any high places? ☐ No ☐ Yes _____

Has your child ever been involved in a motor vehicle accident? ☐ No ☐ Yes _____

Has your child been seen on an emergency basis? ☐ No ☐ Yes _____

Has your child broken any bones? ☐ No ☐ Yes _____

Has your child had any previous hospitalizations? ☐ No ☐ Yes _____

Has your child had any previous surgeries? ☐ No ☐ Yes _____

Does your child use a tablet, computer, or video game? ☐ Never ☐ Rarely ☐ Daily ☐ Several hrs/day

Does your child watch TV? ☐ Never ☐ Rarely ☐ Daily ☐ Several hrs/day

Does your child exercise? ☐ No ☐ Daily ☐ Weekly ☐ Seasonally

Does your child play contact sports? ☐ No ☐ Daily ☐ Weekly ☐ Seasonally

Does your child sleep on their… ☐ Back ☐ Belly ☐ Sides (both, right, left)

Does your child carry a back pack? ☐ No ☐ Yes

Does it weigh less than 15% of their body weight? ☐ No ☐ Yes

Do they wear their back pack on 2 shoulders? ☐ No ☐ Yes

Does your child show excessive or uneven shoe wearing out? ☐ No ☐ Yes

Does your child wear custom orthotics?

☐ No ☐ Yes, For what purpose? _____

Chemical Stressors

Have you chosen to vaccinate your child? ☐ No ☐ Yes, on a delayed schedule ☐ Yes, on schedule

Reason for vaccination: ☐ Personal research ☐ Didn't know I had a choice ☐ It was recommended

Reaction(s) to vaccination: ☐ None ☐ Fever ☐ Diarrhea ☐ Rash ☐ Welt at injection site
☐ Fatigue ☐ Seizures ☐ Prolonged Cry ☐ Developmental Regression
☐ Other: _____

Does your child receive annual flu shots? ☐ No ☐ Yes (personal research) ☐ Yes (MD recommended)

Has your child been exposed to antibiotics? ☐ No ☐ Yes

If yes, how many doses in past 6 months? _____ Reason: _____

Has your child been exposed to medications, including OTC?

If yes, which ones? _____

If yes, how many doses in past 6 months? _____ Reason: _____

How many glasses of water/day does your child have? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many glasses of cow's milk, juice, and soda/day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

Does your child eat gluten? ☐ No ☐ Yes ☐ Trying to eliminate

Does your child eat dairy? ☐ No ☐ Yes ☐ Trying to eliminate

Any food/drink allergies or sensitivities? ☐ No ☐ Yes _____

Is your child exposed to second hand smoke? ☐ No ☐ Yes _____

Does your child take a probiotic daily? ☐ No ☐ Yes _____ CFU's/day

Does your child take a vitamin D3 daily? ☐ No ☐ Yes _____ IU's/day

Does your child take Omega 3 Fish Oils daily? ☐ No ☐ Yes _____ mg/day

Other supplements or homeopathics? _____

Goals & Consent

Do you feel your child is developmentally appropriate for their age?

Intellectually: ☐ Yes ☐ No _____

Emotionally: ☐ Yes ☐ No _____

Physically: ☐ Yes ☐ No _____

What is your primary goal for your child at our clinic? _____

Our goals are to provide a detailed assessment of your child's current health status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You've taken an important step for your child's future through a chiropractic evaluation!

Consent to Evaluation of a Minor Child

I, _____, being the parent or legal guardian of _____,
(print name of consenting adult) *(print name of minor)*

hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, and physical examination. Any findings will be communicated before consenting to commencement of treatment, if appropriate.

_____ _____

Consenting Adult's Signature Date