



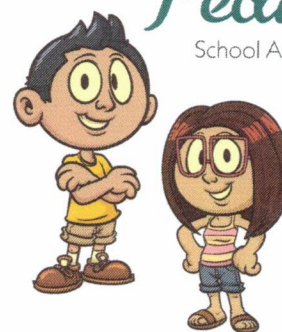
**Adjust to Wellness**  
FAMILY CHIROPRACTIC

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Phone: (902) 861.1500 • [adjusttowellness.ca](http://adjusttowellness.ca)

*Pediatric*

School Aged Children



## Practice Member Information

File \_\_\_\_\_

Child's Name: \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_

Parent's/Guardian's Names: \_\_\_\_\_

Home Address: \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

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: \_\_\_\_\_

May we add you to our email newsletter and calendar of events? ☐ Yes ☐ No (Your email will not be shared)

How did you hear about us? \_\_\_\_\_

Height (of child): \_\_\_\_\_ Weight (of child): \_\_\_\_\_ Birth Date: M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_ Age: \_\_\_\_\_ Sex: ☐ M ☐ F

Siblings and ages: \_\_\_\_\_

Previous Chiropractic Care? ☐ Yes ☐ No

## Emergency Contact

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone number: \_\_\_\_\_ Alternate 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, Massage Therapist, etc)

Name: \_\_\_\_\_

Professional Designation: \_\_\_\_\_

Date and reason of last visit: \_\_\_\_\_

Name: \_\_\_\_\_

Professional Designation: \_\_\_\_\_

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

Do you have a specific concern that brings you in?

☐ No, I'm interested in having my child's nervous system assessed to achieve optimal health and functioning.

☐ Yes: \_\_\_\_\_

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? \_\_\_\_\_ How long has your child been experiencing this? \_\_\_\_\_

Is it getting better, worse or staying the same? \_\_\_\_\_ Was the onset sudden or gradual? \_\_\_\_\_

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

Did they receive any treatment at the time? . . . . . ☐ No ☐ Yes

Has your child had x-rays in relation to 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, if so, how many? \_\_\_\_\_

Medications during pregnancy: ☐ No ☐ Yes \_\_\_\_\_

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

Exposure to alcohol, cigarettes or second hand smoke during pregnancy: ☐ No ☐ Yes \_\_\_\_\_





## Birth Experience

Location of Birth: ☐ Home ☐ Hospital ☐ Birthing Centre ☐ 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 an intra-uterine constraining position? ☐ No ☐ Yes ☐ Unsure  
If yes, please describe: ☐ Breech ☐ Transverse ☐ Face / Brow presentation \_\_\_\_\_

Was your delivery vaginal or C-section? \_\_\_\_\_ If it was a 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 during delivery? ☐ Forceps ☐ Vacuum Extraction ☐ Other \_\_\_\_\_

Were there any complications during delivery? ☐ Yes ☐ No \_\_\_\_\_  
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? \_\_\_\_ w \_\_\_\_ d / Birth Weight: \_\_\_\_ lbs \_\_\_\_ oz / Birth Length: \_\_\_\_ Inches

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

Was the baby ever administered to Neonatal Intensive Care? ☐ No ☐ Yes \_\_\_\_\_  
If yes, for how long and why? \_\_\_\_\_

Was any medication given to the baby at birth? ☐ Yes ☐ No ☐ 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, frequent spit up)? ☐ 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/Do you practice attachment parenting methods:  
(cosleeping, kangaroo care, elimination communication, feeding on demand, extended breastfeeding etc) ☐ No ☐ Yes \_\_\_\_\_

Did your child spend excess time in any baby devices such as: bouncer 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 or near miss? . . . . . ☐ 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 spend time using a tablet, computer or video games? . . . . . ☐ 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 ☐ Sometimes

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

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

If yes, how many doses in past 6 months? \_\_\_\_\_ Reason \_\_\_\_\_

Were probiotics used at the same time as antibiotics? ☐ No ☐ Yes

Has your child been exposed to medications, including OTC: ☐ No ☐ Yes

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 does your child have: . . ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

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

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

Does your child eat refined sugars (white sugar), white bread and pasta? . . ☐ No ☐ Yes ☐ Trying to eliminate from diet

Does your child eat boxed/frozen foods? . . . . . ☐ No ☐ Yes ☐ Trying to eliminate from diet

Do you choose organic foods? ☐ No ☐ Yes If yes, which: ☐ Veggies ☐ Fruits ☐ Meats ☐ Grains ☐ All

Does your child eat any artificial sweeteners like Splenda, Aspartame, AminoSweet, Diet Soda? ☐ No ☐ Yes

Does your child follow any other dietary restrictions? ☐ No ☐ Yes \_\_\_\_\_

Any food/drink allergies, sensitivities, intolerances? ☐ 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 vitamin D3 daily? ☐ No ☐ Yes: \_\_\_\_\_ IU's/day

Does your child take Omega 3 Fish Oils daily? ☐ No ☐ Yes: \_\_\_\_\_ mg/day ☐ Capsule ☐ Liquid

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, examination and x-rays if warranted. Any findings will be communicated before consenting to commencement of care, if appropriate.

\_\_\_\_\_  
Consenting Adult's Signature

\_\_\_\_\_  
Date