



Dr. Sandra Moore

1877 North Getty Street
Muskegon, MI, 49445

231-744-5200
lakewindschiro.com

Pediatric

Infants & Toddlers



Practice Member Information

File _____

Child's Name: _____ M _____ D _____ Y _____

Parent's/Guardian's Names: _____

Home Address: _____

City _____ State _____ Zip _____

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: _____

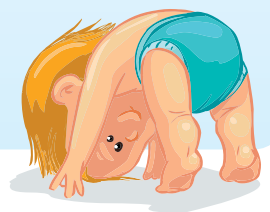
Name: _____

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	
☐	☐	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	☐	☐	Regression of Milestones
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joint	☐	☐	Tremors / Shaking
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	ADD / ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying Spells	☐	☐	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? ☐ 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 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? _____

Child Health History (Answer only those which are applicable)

How many hours does your baby sleep between feedings? _____ Day _____ Night
Does your child have a preferred sleeping position? ☐ No ☐ Yes _____
Does your child have any feeding difficulties? ☐ No ☐ Yes _____
Is your child currently being breast fed? ☐ Yes: exclusively breastfed ☐ formula supplemented ☐ No
If no, how long was the baby breast fed? _____ weeks/months
Does your child have a one-sided breast preference? ☐ No ☐ Yes If yes, Prefer Left or Right _____
Does your child frequently spit up after feeding? ☐ No ☐ Yes
Does your child cry often? ☐ No ☐ Yes If yes, approximately how many hours per day? _____
Does your child pass a lot of intestinal gas? ☐ No ☐ Yes
Does your child frequently arch his/her head and neck backwards? ☐ No ☐ Yes
Has your child shown any sensitivities to foods either in your diet or their own? ☐ No ☐ Yes _____
Is your child exposed to cow's milk/dairy? ☐ No ☐ Yes, formula ☐ Yes, directly ☐ Yes, I drink it and breastfeed.

Developmental History

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 _____



Chemical Stressors

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

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

Reaction(s) to vaccination: ☐ Fever ☐ Welt at injection site ☐ Rash ☐ Diarrhea ☐ Fatigue ☐ Prolonged Cry
☐ Seizures ☐ Developmental Regression ☐ Other _____

Does your child receive annual flu shots? ☐ No ☐ Yes (informed decision) ☐ Yes (recommended by MD)

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