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Pediatric

School Aged Children



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 Sensitivites		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 constricting 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

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 Welp 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