OAKTREE | CHIROPRACTIC ACUPUNCTURE CHINESE MEDICINE

CHILD (ages 2-10) Chiropractic Health Form

PERSONAL INFORMATION

Name of Child: _____ Gender: _____

Name of Parent(s): _____

Address: _____ City: _____ Postal Code: _____

Home #: _____ Cell #: _____ Office #: _____

Email: _____

☐ Yes ☐ No I consent to receiving email communication from Oaktree

(Emails we will send you include news updates from Oaktree. We will not spam you and you can unsubscribe at anytime. You will still receive appointment reminders and other important notices via email)

Birth date: [M]_____ [D]_____ [Y]_____ Age: _____ Weight: _____ Height: _____

MD name: _____

Referred by: _____

CHIROPRACTIC HISTORY

Have you ever been to a chiropractor before? ☐ Yes ☐ No Were x-rays taken? ☐ Yes ☐ No

Name of Chiropractor: _____ City: _____

Date of last visit: [M]_____ [Y]_____ Duration & Frequency of Care: _____

I understand that the purpose of today's visit is to determine if my child is a candidate for chiropractic care and that I am responsible for any fees agreed upon between myself and the attending doctor. All examination fees will be explained to me before any tests are performed.

_____ _____

Signature Date

OAKTREE | CHIROPRACTIC ACUPUNCTURE CHINESE MEDICINE

HEALTH CONCERNS

What is the purpose of today's visit? ☐ Wellness Check-up ☐ Specific Concern (fill out below)

1. What is the present primary health concern for your child? _____

_____

How long has your child had this condition? _____

What other health care professionals have treated this condition? What else have you tried?

_____

Is the problem: ☐ getting better ☐ getting worse ☐ staying the same

Please rate the problem on how you think this is affecting your child:

(Not affecting at all) 0 1 2 3 4 5 6 7 8 9 10 (Affecting a lot)

Please rate the problem on how you think this is affecting your family:

(Not affecting at all) 0 1 2 3 4 5 6 7 8 9 10 (Affecting a lot)

2. If applicable, what is the present secondary health concern for your child? _____

_____

How long has your child had this condition? _____

What other health care professionals have treated this condition? What else have you tried?

_____

Is the problem: ☐ getting better ☐ getting worse ☐ staying the same

Please rate the problem on how you think this is affecting your child:

(Not affecting at all) 0 1 2 3 4 5 6 7 8 9 10 (Affecting a lot)

Please rate the problem on how you think this is affecting your family:

(Not affecting at all) 0 1 2 3 4 5 6 7 8 9 10 (Affecting a lot)

Please share any additional health problems, concerns, or information: _____

_____

_____

_____

OAKTREE | CHIROPRACTIC ACUPUNCTURE CHINESE MEDICINE

CHEMICAL STRESSORS

Any food intolerances? ☐ Yes ☐ No If yes, list:_____

Has your child had any vaccinations? ☐ Yes ☐ No ☐ Modified schedule

Has your child ever had antibiotics? ☐ Yes ☐ No If yes, list:_____

Total number of antibiotic rounds to date: _____

Does your child take any medication(s)? Which and for what conditions(s)?: _____

_____

TRAUMATIC STRESSORS

Falls your child has experienced (i.e. from a bed, change table, down stairs, off couch, etc.):

_____

_____

Has your child ever been hospitalized post birth? ☐ Yes ☐ No Comment:_____

_____

Has your child ever had surgery? ☐ Yes ☐ No Comment:_____

_____

Has your child ever been involved in a car accident? ☐ Yes ☐ No Comment:_____

_____

Does your child play any high impact sports? ☐ Yes ☐ No List:_____

_____

How often does the child participate in aerobic exercises? (at least 30 minutes per day)

☐ 0 days/week ☐ 1-2 days/week ☐ 3-4 days/week ☐ 5-7 days/week

CONDITIONS & SYMPTOMS

☐ Asthma

☐ Frequent colds/low immune system

☐ Sinus problems

☐ Constipation/diarrhea

☐ Irritable bowel syndrome

☐ Crohn's disease

☐ Ulcers

☐ Skin problems

☐ Seizures

☐ Headaches/migraines

☐ Neck pain/stiffness

☐ Tension across shoulders

☐ Mid-back pain/stiffness

☐ Low-back pain/stiffness

☐ Faulty posture

☐ Poor memory/concentration

☐ Learning disability

☐ Irritable/nervous

☐ Scoliosis

☐ Autism

☐ ADHD

☐ Other sensory processing disorder

☐ Depression/emotional issues

☐ Anxiety

☐ Tired/lethargic

☐ Digestive trouble

☐ Food allergy: _____

_____

☐ Other: _____