MINDARIE KEYS CHIROPRACTIC & WELLNESS CENTRE

Child's Name _____ Birth Date M____D____Y____

Parent's / Guardian's Name _____

Home Address _____

City_____State _____ Postcode _____

Home Phone: _____

Parent's Mobile Phone: _____

Parent's Email: _____

Pediatrician/GP Name & Location: _____

How did you hear about us? _____

Height (of child): _____ Weight (of child): _____ Age: _____ Sex: ☐ M ☐ F

Siblings and ages: _____

Previous Chiropractic Care? ☐ Yes ☐ No

PATIENT HEALTH INFORMATION & WELLNESS PROFILE

The human body is designed to be healthy. The primary system in the body which coordiantes 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 contribution to vertebral subluxation and impeding your child's ***ability to heal***.

Chief Complaint(s):

_____

Is the problem (circle): progressively getting worse / staying the same / getting better
constant / frequent / occasional?

Has your child been treated for this condition? Y/N
If so, when? _____

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.

PRENATAL PROFILE

Type of Birth (circle all that apply) vaginal / forceps / breech / c-section / home / birthing centre / hospital / other:

_____

What was the gestation period for your child? _____

How long was the entire labor? _____

Was it spontaneous or induced? _____

Problems/complications during pregnancy / during labor / delivery? _____

Infant feeding (circle): breast / bottle / formula - If formula, what type? _____

Any difficulty feeding? ☐Yes ☐No Explain _____

Quality of sleep: good / fair / poor - Hours per day: _____ Hours per night: _____

Immunizations: Yes / No - Specify: _____

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

Surgery and / or Hospitalisation: ☐Yes ☐No Explain: _____

Medications or Antibodies _____

Most recent fall: _____

Other significant falls / trauma / motor vehicle accident(s): _____

Any broken bone? past / present

Other significant falls / trauma / motor vehicle accident(s): _____

Sports and recreational activities: _____

Do you feel your child is developing appropriately for his/her age? ☐Yes ☐No

Vertebral Subluxation can cause irritation to different nerves that can affect any organ or tissue, causing conditions now or in the future.

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	☐	☐	Headache/Migraines	☐	☐	Weight Challenges
☐	☐	Tonsilitis	☐	☐	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

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.

Missed Appointments: Please give at least 8 hours notice if you cannot keep an appointment. We have a telephone message centre for your convenience. We will return your call as soon as possible. We do have a $50 missed appointment fee that may be enforced.

I, _____ have read and fully understand the above statements and accept chiropractic care for my child on this basis.

_____ _____

Signature Date