Soulshine Family Wellness Center

25 Sheridan Ave.
Ho-Ho-Kus, NJ 07423

Child Information

Date _____

Child's Name: _____

Parent(s) Name: _____

Siblings' Names and Ages: _____

Address _____ City/Town _____ Postal Code _____

Parents' E-mail Address _____

Would you like to receive our "Living Healthy" e-newsletter? ◯ Yes ◯ No

Date of Birth _____m/_____d/_____y/ Sex: ◯ Male ◯ Female

Home Ph _____ Business Ph _____ Mobile Ph _____

Best time/ place to contact you? _____

Whom may we thank for referring your child to this office? _____

Circle the phrase that most represents your child's reason for care:
◯ Wellness ◯ Prevention ◯ Feel good ◯ Symptom Relief

Reason for your child seeking services at our office: _____

Has your child ever seen a Chiropractor? If yes, who? Date of last visit: _____

Name & Address of Obstetrician/ Midwife:_____

Name & Address of Primary Health Care Provider:_____

Date of last visit _____ Purpose of visit _____

Health Concerns

Please list your child's heath concerns according to their severity:

Concern	Rate of Severity 1=mild, 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is pain present?
1.					
2.					
3.					
4.					

Pregnancy and Birth History

Gestational Duration: _____ weeks

PHYSICAL STRESS

Trauma/Falls during pregnancy_____

How many and for what reasons? _____

Invasive Procedures (Eg. Amniocentesis, CVS) ? ◯ Yes ◯ No

CHEMICAL STRESS

During the pregnancy did the mother:

Smoke? ◯ Yes ◯ No How much? _____

Drink Alcohol? ◯ Yes ◯ No How much? _____

Prescription Medications? ◯ Yes ◯ No How much? _____

Recreational Drugs? ◯ Yes ◯ No How much? _____

Fall ill during pregnancy? ◯ Yes ◯ No please explain _____

Were any supplements taken during the pregnancy? ◯ Yes ◯ No

Please list: _____

EMOTIONAL STRESS

Please rate your stress levels during pregnancy 1-10 (1= low, 10=high):_____

LABOR

Was labor induced? ◯ Yes ◯ No

Duration of labor? _____

Duration of active (pushing stage) labor?_____

Did mother receive medications? ◯ Yes ◯ No

If yes, which: _____

BIRTH

Type of birth? ◯ Vaginal: Cephalic (head first) ◯ Breech (feet first) ◯ C-Section

Location of birth? ◯ Home ◯ Hospital ◯ Birthing center

Birth Assistants? ◯ Midwife ◯ Doula ◯ Obstetrician

Was there any assistance needed during birth?

◯ Forceps ◯ Cesarean ◯ Vacuum Extraction ◯ Induction ◯ Assisted Traction/Head Turning

Was delivery considered normal? ◯ Yes ◯ No

Were there complications during birth? ◯ Yes ◯ No

Please explain:

_____

Was there any evidence of birth trauma to the infant? Check all that apply:

◯ Bruising ◯ Odd shaped head

◯ Stuck in birth canal ◯ Fast or excessively long birth

◯ Respiratory depression ◯ Cord around neck

Was your child given any of the following? Check all that apply:

◯ Silver nitrate drops in eyes ◯ Incubation How long? _____

◯ Vitamin K shot ◯ Separation from you How long? _____

◯ Hepatitis shot

Did your child spend any time in intensive care? Yes No If yes, how long? _____

APGAR score at birth? _____ APGAR score at 5 minutes? _____

Birth Weight? _____ Birth Length? _____

Childhood History

PHYSICAL STRESS

Does your child have a preferred sleeping position? ◯ Yes ◯ No _____

Did your child prefer one-sided breast-feeding position? ◯ Yes ◯ No _____

Did your baby spit up after feeding? ◯ Yes ◯ No

_____

Any falls or injuries down stairs, bicycle etc? ◯ Yes ◯ No _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their firstyear of life (i.e., a bed, changing table, downstairs, etc.)

Was this the case with your child? ◯ YES ◯ NO

Comments_____

_____

_____

Does child ever bang his/her head repeatedly? ◯ Yes ◯ No _____

Any traumas resulting in bruises, fractures, stitches? ◯ Yes ◯ No _____

Any hospitalizations or surgeries? ◯ Yes ◯ No _____

Please list all surgeries your child has had:
1. Type _____ When _____ Doctor _____

2. Type _____ When _____ Doctor _____

Please list any accidents and/or injuries: auto, sports, or other (Especially those related to your child's present problems).
1. Type_____ When_____ Hospitalized? ◯ Yes ◯ No

2. Type_____ When_____ Hospitalized? ◯ Yes ◯ No

3. Type_____ When_____ Hospitalized? ◯ Yes ◯ No

Have you ever had x-rays taken? ◯ Yes ◯ No When?_____ Where?_____

What area of your child's body:_____

Does your child play sports? ◯ Yes ◯ No _____

If yes, hours per week? _____ Age child began? _____

Is school backpack used? ◯ Yes ◯ No Weight of backpack? _____kg/lbs

Approximate hours spent at play per week? _____

Average time spent at computer/TV/video games per week? _____ hrs

Does your child wear glasses or contact lenses? ◯ Yes ◯ No _____
Does your child have trouble reading the board? ◯ Yes ◯ No _____
Does your child have difficulty with coordination? ◯ Yes ◯ No _____

CHEMICAL STRESS

Was/is child breast-fed? ◯ Yes ◯ No For how long? _____

At what age was:

Formula introduced? _____ Brand? _____

Cow's milk introduced? _____

Solid food? _____

Food/juice intolerance? ◯ Yes ◯ No_____
Does your child have food allergies? ◯ Yes ◯ No_____

What is your child's favorite food? _____

What does your child regularly drink? _____

The type of diet your child usually follows is classified as: _____

Please circle any dietary selection that is appropriate for your child, and grade according to the following scale:

Daily:
D - Consume this daily
FD - Consume this a few times per day

Monthly:
M - Consume this monthly
FM - Consume a few times per month

Weekly:
W - Consume this weekly
FW - Consume this a few times per week

Never:
O - Do not consume this

Eggs_____ Fasting_____ Fruit_____ Fish____ Diet Food_____
Organic Foods _____ Coffee_____ Beef_____ Weight Control Diet_____ Raw Vegetables_____
Soft Drink_____ Poultry____ Artificial Sweetener_____ Whole Grains_____ Fried Foods_____
Seafood_____ Cooked vegetables_____ Refined Sugar_____ Dairy_____
Canned/Frozen vegetable____

Does your child have a bowel movement every day? ◯ Yes ◯ No _____

Does your child have regular or occasional skin rashes? ◯ Yes ◯ No _____

Were vaccinations given? If so at what age_____
_____

Were there any negative reactions? ◯ Yes ◯ No _____

Was there any:

◯ Fever ◯ Un-consolable crying

◯ Irritability ◯ Arching of body

◯ Bowel disturbances ◯ Feeding disturbances

◯ Drowsiness ◯ Other: _____

History of antibiotics? ◯ Yes ◯ No

If so, how many coursed of antibiotics has your child received in their lifetime? _____

Reason and length of last course of antibiotics? _____

Please list ALL medications your child currently takes or has taken in the past 6 months:

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Please list all nutritional supplements, vitamins, homeopathic remedies your child presently takes:

Name _____ For what? _____

Name _____ For what? _____

Are there any smokers at home? ◯ Yes ◯ No _____

EMOTIONAL STRESS

Did mother have any difficulties with breast-feeding? ◯ Yes ◯ No

Did mother and baby have difficulty bonding? ◯ Yes ◯ No

Did mother experience any post-partum depression? ◯ Yes ◯ No

Night terrors, sleep walking, difficulty sleeping ◯ Yes ◯ No _____

Do you consider their sleeping pattern normal? ◯ Yes ◯ No _____

Quality of Sleep? ◯ Good ◯ Fair ◯ Poor Number of hours _____

Behavior problems? ◯ Yes ◯ No _____

Do you feel that your child's social and emotional development is normal for their age? ◯ Yes ◯ No

Does your child attend day care? ◯ Yes ◯ No From what age? _____

GROWTH AND DEVELOPMENT

Are you aware of any developmental delays for your child? ◯ Yes ◯ No

If yes, please explain: _____

Do siblings have any health concerns? ◯ Yes ◯ No

If yes, please describe: _____

_____ _____

Parents Signature Date