

PEDIATRIC SPINAL HEALTH SCREENING

To determine if any health problems you are experiencing may be improved through Chiropractic.

NOTE: This is NOT a diagnosis, and while Andreone Sports & Family Chiropractic agrees never to sell or distribute, in any way, any of your information listed below, you do grant us permission to contact you about any appointment you make on this day, or to provide you with information about our office.

Child's Name	DOB	Parent's Name	
Address	City	Zip	Home Phone:
Email	Date	Previous Chiropractic Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
SSN:	Primary Ins. Holder's Name:	Primary Ins. Holder's SSN:	

1. Is your child **currently** benefiting from chiropractic care? Yes No When was their last visit? _____

2. Check any of the following conditions your child has suffered from during the past six months:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> - Headaches | <input type="checkbox"/> - Tight/Sore Muscles | <input type="checkbox"/> - ADD / ADHD | <input type="checkbox"/> - Growing Pains |
| <input type="checkbox"/> - Sinus Problems | <input type="checkbox"/> - Scoliosis | <input type="checkbox"/> - Car Accident / Trauma | <input type="checkbox"/> - Back Pains |
| <input type="checkbox"/> - Ear Infections | <input type="checkbox"/> - Digestive Problems | <input type="checkbox"/> - Chronic Colds | <input type="checkbox"/> - Poor Posture |
| <input type="checkbox"/> - Asthma / Allergies | <input type="checkbox"/> - Bed Wetting | <input type="checkbox"/> - Recurring Fevers | <input type="checkbox"/> - Sports Injuries |
| <input type="checkbox"/> - Colic | <input type="checkbox"/> - Seizures | <input type="checkbox"/> - Temper Tantrums | <input type="checkbox"/> - Trouble Sleeping |

Other health problems: _____ Currently taking medications: - Yes - No

3. How long have your child been living this way? Weeks (#) _____ Months (#) _____ Years (#) _____

4. According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, changing table, etc.) during their first year of life. Has this happened to your child? Yes No

5. **Circle Appropriately**

Birth Place: Home / Hospital / Birth Center
 Type: Vaginal / C-Section
 Procedures: Forceps / Vacuum Extraction
 Vaccinations: - Following MD's recommendations
 - I have chosen to not vaccinate my child.
 Food: Breast Fed - Yes - No How Long? _____
 Any Known Food Allergies? - Yes - No

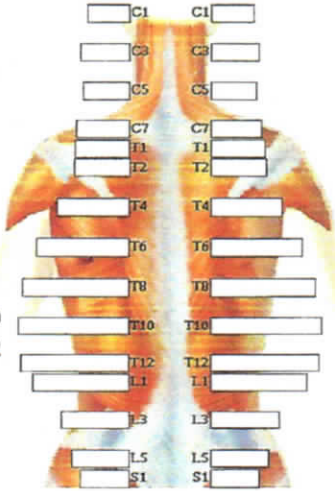
6.

Circle Appropriately

Which contact sports does your child participate in?
 Soccer / Football / Gymnastics / Karate / Hockey
 Basketball / Dance / Cheering / Other: _____
 Last Neurological Scan by Pediatrician: _____
 - Surface EMG - Thermography
 Last Postural Exam by Pediatrician: _____

7. What Health Goals do you want for your child? - Reduce Pain - Restore Health - **OPTIMUM** Health

8. How many prescriptions has your child taken?: During last 6 months? _____ During lifetime? _____

<p style="text-align: center;">Examination Results:</p> <p>Posture Notes: _____</p> <p>_____</p> <p>_____</p> <p>Leg Check Analysis: _____</p> <p>_____</p> <p>Strength Tests: _____</p> <p>_____</p> <p>Motion Palpation of Spine: _____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;">FOR OFFICE USE ONLY:</p> <p style="text-align: center;">S=severe(red); M=mild(blue); L=light(green); N=normal(white)</p> <table style="width: 100%; text-align: center;"> <tr> <td>SMLN - C1</td> <td><input type="checkbox"/> C1</td> <td>C1 <input type="checkbox"/></td> <td>C1 - NLMS</td> </tr> <tr> <td>SMLN - C3</td> <td><input type="checkbox"/> C3</td> <td>C3 <input type="checkbox"/></td> <td>C3 - NLMS</td> </tr> <tr> <td>SMLN - C5</td> <td><input type="checkbox"/> C5</td> <td>C5 <input type="checkbox"/></td> <td>C5 - NLMS</td> </tr> <tr> <td>SMLN - C7</td> <td><input type="checkbox"/> C7</td> <td>C7 <input type="checkbox"/></td> <td>C7 - NLMS</td> </tr> <tr> <td>SMLN - T1</td> <td><input type="checkbox"/> T1</td> <td>T1 <input type="checkbox"/></td> <td>T1 - NLMS</td> </tr> <tr> <td>SMLN - T2</td> <td><input type="checkbox"/> T2</td> <td>T2 <input type="checkbox"/></td> <td>T2 - NLMS</td> </tr> <tr> <td>SMLN - T4</td> <td><input type="checkbox"/> T4</td> <td>T4 <input type="checkbox"/></td> <td>T4 - NLMS</td> </tr> <tr> <td>SMLN - T6</td> <td><input type="checkbox"/> T6</td> <td>T6 <input type="checkbox"/></td> <td>T6 - NLMS</td> </tr> <tr> <td>SMLN - T8</td> <td><input type="checkbox"/> T8</td> <td>T8 <input type="checkbox"/></td> <td>T8 - NLMS</td> </tr> <tr> <td>SMLN - T10</td> <td><input type="checkbox"/> T10</td> <td>T10 <input type="checkbox"/></td> <td>T10 - NLMS</td> </tr> <tr> <td>SMLN - T12</td> <td><input type="checkbox"/> T12</td> <td>T12 <input type="checkbox"/></td> <td>T12 - NLMS</td> </tr> <tr> <td>SMLN - L1</td> <td><input type="checkbox"/> L1</td> <td>L1 <input type="checkbox"/></td> <td>L1 - NLMS</td> </tr> <tr> <td>SMLN - L3</td> <td><input type="checkbox"/> L3</td> <td>L3 <input type="checkbox"/></td> <td>L3 - NLMS</td> </tr> <tr> <td>SMLN - L5</td> <td><input type="checkbox"/> L5</td> <td>L5 <input type="checkbox"/></td> <td>L5 - NLMS</td> </tr> <tr> <td>SMLN - S1</td> <td><input type="checkbox"/> S1</td> <td>S1 <input type="checkbox"/></td> <td>S1 - NLMS</td> </tr> </table> 	SMLN - C1	<input type="checkbox"/> C1	C1 <input type="checkbox"/>	C1 - NLMS	SMLN - C3	<input type="checkbox"/> C3	C3 <input type="checkbox"/>	C3 - NLMS	SMLN - C5	<input type="checkbox"/> C5	C5 <input type="checkbox"/>	C5 - NLMS	SMLN - C7	<input type="checkbox"/> C7	C7 <input type="checkbox"/>	C7 - NLMS	SMLN - T1	<input type="checkbox"/> T1	T1 <input type="checkbox"/>	T1 - NLMS	SMLN - T2	<input type="checkbox"/> T2	T2 <input type="checkbox"/>	T2 - NLMS	SMLN - T4	<input type="checkbox"/> T4	T4 <input type="checkbox"/>	T4 - NLMS	SMLN - T6	<input type="checkbox"/> T6	T6 <input type="checkbox"/>	T6 - NLMS	SMLN - T8	<input type="checkbox"/> T8	T8 <input type="checkbox"/>	T8 - NLMS	SMLN - T10	<input type="checkbox"/> T10	T10 <input type="checkbox"/>	T10 - NLMS	SMLN - T12	<input type="checkbox"/> T12	T12 <input type="checkbox"/>	T12 - NLMS	SMLN - L1	<input type="checkbox"/> L1	L1 <input type="checkbox"/>	L1 - NLMS	SMLN - L3	<input type="checkbox"/> L3	L3 <input type="checkbox"/>	L3 - NLMS	SMLN - L5	<input type="checkbox"/> L5	L5 <input type="checkbox"/>	L5 - NLMS	SMLN - S1	<input type="checkbox"/> S1	S1 <input type="checkbox"/>	S1 - NLMS
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**CONSENT TO TREATMENT
OF A MINOR CHILD**

I hereby authorize Dr. Christopher P. Andreone and/or his staff to examine and/or treat my

_____ **Indicate Relationship and First Name of Child**

Full Name of Child _____

Address _____

Dated: _____

Signed: _____

Witness: _____