ANDREONE SPORTS & FAMILY CHIROPRACTIC
PEDIATRIC SPINAL HEALTH SCREENING

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

Child's Name _____ DOB _____ Parent's Name _____

Address _____ City _____ Zip _____ Home Phone: _____

Email _____ Date _____ Previous Chiropractic Care ☐ Yes ☐ 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:

☐ - Headaches	☐ - Tight/Sore Muscles	☐ - ADD / ADHD	☐ - Growing Pains
☐ - Sinus Problems	☐ - Scoliosis	☐ - Car Accident / Trauma	☐ - Back Pains
☐ - Ear Infections	☐ - Digestive Problems	☐ - Chronic Colds	☐ - Poor Posture
☐ - Asthma / Allergies	☐ - Bed Wetting	☐ - Recurring Fevers	☐ - Sports Injuries
☐ - Colic	☐ - Seizures	☐ - Temper Tantrums	☐ - 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? _____

Examination Results:

Posture Notes: _____

Leg Check Analysis: _____

Strength Tests: _____

Motion Palpation of Spine: _____

FOR OFFICE USE ONLY:

S=severe(red); M=mild(blue); L=light(green); N=normal(white)

S M L N – C1	C1 C1	C1 – N L M S
S M L N – C3	C3 C3	C3 – N L M S
S M L N – C5	C5 C5	C5 – N L M S
S M L N – C7	C7 C7	C7 – N L M S
S M L N – T1	T1 T1	T1 – N L M S
S M L N – T2	T2 T2	T2 – N L M S
S M L N – T4	T4 T4	T4 – N L M S
S M L N – T6	T6 T6	T6 – N L M S
S M L N – T8	T8 T8	T8 – N L M S
S M L N – T10	T10 T10	T10 – N L M S
S M L N – T12	T12 T12	T12 – N L M S
S M L N – L1	L1 L1	L1 – N L M S
S M L N – L3	L3 L3	L3 – N L M S
S M L N – L5	L5 L5	L5 – N L M S
S M L N – S1	S1 S1	S1 – N L M S