



## Practice Member Information

File \_\_\_\_\_

Child's Name: \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_

Parent's/Guardian's Names: \_\_\_\_\_

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ May we leave a message? Yes No

Parent's Cell Phone: \_\_\_\_\_ May we leave a message? Yes No

Parent's Work Phone: \_\_\_\_\_ May we leave a message? Yes No

Parent's Email: \_\_\_\_\_

May we add you to our email newsletter and calendar of events? Yes No (Your email will not be shared)

How did you hear about us? \_\_\_\_\_

Height (of child): \_\_\_\_\_ Weight (of child): \_\_\_\_\_ Birth Date: M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Siblings and ages: \_\_\_\_\_

Previous Chiropractic Care? Yes No

### Emergency Contact

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone number: \_\_\_\_\_ Alternate phone number: \_\_\_\_\_

### Family Doctor

Name: \_\_\_\_\_ Professional Designation: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Date and reason of last visit: \_\_\_\_\_

May we communicate with your family doctor regarding your child's care if necessary? Yes No

### Other Health Care Professionals

(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, Massage Therapist, etc)

Name: \_\_\_\_\_

Professional Designation: \_\_\_\_\_

Date and reason of last visit: \_\_\_\_\_

Name: \_\_\_\_\_

Professional Designation: \_\_\_\_\_

Date and reason of last visit: \_\_\_\_\_

### 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.



## Wellness Profile

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

### 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		Headaches/Migraines		Weight Challenges
	Tonsillitis		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

Do you have a specific concern that brings you in?

No, I'm interested in having my child's nervous system assessed to achieve optimal health and functioning.

Yes: \_\_\_\_\_

*If yes, please answer the following questions:*

Does your child appear to be in pain or discomfort? \_\_\_\_\_ How long has your child been experiencing this? \_\_\_\_\_

Is it getting better, worse or staying the same? \_\_\_\_\_ Was the onset sudden or gradual? \_\_\_\_\_

Have you seen other health professionals regarding this complaint?

No if Yes, whom? \_\_\_\_\_

What treatment did they use? \_\_\_\_\_

Has your child taken any medication for this complaint? . . . . . No Yes \_\_\_\_\_

Has your child ever experienced this complaint before? . . . . . No Yes \_\_\_\_\_

Did they receive any treatment at the time? . . . . . No Yes \_\_\_\_\_

Has your child had x-rays in relation to the current complaint? . . No Yes \_\_\_\_\_

## Prenatal Profile

Adopted Prenatal history unknown Birth history unknown

Complications during pregnancy: No Yes (Brief description) \_\_\_\_\_

Ultrasounds during pregnancy: No Yes, if so, how many? \_\_\_\_\_

Medications during pregnancy: No Yes \_\_\_\_\_

If so which ones and how often? (include OTC): \_\_\_\_\_

Exposure to alcohol, cigarettes or second hand smoke during pregnancy: No Yes \_\_\_\_\_

## Birth Experience

Location of Birth: Home Hospital Birthing Centre Other \_\_\_\_\_  
 Birth Attendants: Doula Midwife GP OB Other \_\_\_\_\_  
 Medications during labor / delivery (including IV antibiotics) No Yes \_\_\_\_\_  
 Was Pitocin used to induce / speed up labor? No Yes \_\_\_\_\_  
 Were your membranes ruptured by a medical professional? No Yes \_\_\_\_\_  
 Was your child at anytime during your pregnancy in an intra-uterine constricting position? No Yes Unsure  
 If yes, please describe: Breech Transverse Face / Brow presentation \_\_\_\_\_  
 Was your delivery vaginal or C-section? \_\_\_\_\_ If it was a C-section, was it planned or emergency? \_\_\_\_\_  
 If it was vaginal, was the baby presented: Head Face Breech \_\_\_\_\_  
 Were any of the following interventions used during delivery? Forceps Vacuum Extraction Other \_\_\_\_\_  
 Were there any complications during delivery? Yes No \_\_\_\_\_  
 If yes, please specify: \_\_\_\_\_  
 How long was the labor from the first regular contractions to the birth? \_\_\_\_\_ Hours  
 How long was the second stage (the pushing phase) of the labor? \_\_\_\_\_ Hours  
 Was the baby born with any purple markings / bruising on their face or head? No Yes \_\_\_\_\_  
 Any concerns about misshapen head at birth? No Yes \_\_\_\_\_

## Post Natal & Infant History

How many weeks gestation was the baby at birth? \_\_\_w \_\_\_d / Birth Weight: \_\_\_lbs \_\_\_oz / Birth Length: \_\_\_Inches  
 If known, APGAR scores at: 1 minute \_\_\_\_\_ /10 5 minutes \_\_\_\_\_ /10  
 Was the baby ever administered to Neonatal Intensive Care? No Yes \_\_\_\_\_  
 If yes, for how long and why? \_\_\_\_\_  
 Was any medication given to the baby at birth? Yes No Unsure \_\_\_\_\_  
 If yes, what medication and why? \_\_\_\_\_  
 Was your child exclusively breastfed? No Yes \_\_\_\_\_ months  
 Was your child breastfed + formula fed? No Yes \_\_\_\_\_ months  
 Did your child show any sensitivities to formula (reflux, eczema, arching back, frequent spit up)? No Yes \_\_\_\_\_  
 What age did you introduce solid foods to your child? \_\_\_\_\_ months  
 Did you introduce cereal or grains within your child's first year? No Yes \_\_\_\_\_  
 Did/Do you practice attachment parenting methods:  
 (cosleeping, kangaroo care, elimination communication, feeding on demand, extended breastfeeding etc) No Yes \_\_\_\_\_  
 Did your child spend excess time in any baby devices such as: bouncer seats, swings, bumbos, car seats etc?  
 No Yes, Which ones? \_\_\_\_\_

## Physical Traumas

Has your child ever fallen from any high places? . . . . . No Yes \_\_\_\_\_  
 Has your child ever been involved in a motor vehicle accident or near miss? . . . . . No Yes \_\_\_\_\_  
 Has your child been seen on an emergency basis? . . . . . No Yes \_\_\_\_\_  
 Has your child broken any bones? . . . . . No Yes \_\_\_\_\_  
 Has your child had any previous hospitalizations? . . . . . No Yes \_\_\_\_\_  
 Has your child had any previous surgeries? . . . . . No Yes \_\_\_\_\_  
 Does your child spend time using a tablet, computer or video games? . . . . . Never Rarely Daily Several hrs/day  
 Does your child watch tv? . . . . . Never Rarely Daily Several hrs/day  
 Does your child exercise? . . . . . No Daily Weekly Seasonally  
 Does your child play contact sports? . . . . . No Daily Weekly Seasonally  
 Does your child sleep on their . . . . . Back Belly Sides (Both, Right, Left)  
 Does your child carry a back pack? . . . . . No Yes  
 Does it weigh less than 15% of their body weight? . . . . . No Yes  
 Do they wear their back pack on 2 shoulders? . . . . . No Yes Sometimes  
 Does your child show excessive or uneven shoe wearing out? . . . . . No Yes  
 Does your child wear custom orthotics?  
 No Yes, For what purpose? \_\_\_\_\_

## Chemical Stressors

Have you chosen to vaccinate your child? No Yes, on a delayed or selective schedule Yes, on schedule  
 Reason for vaccination: Informed decision Didn't know I had a choice It was recommended  
 Reaction(s) to vaccination: Fever Welt at injection site Rash Diarrhea Fatigue Prolonged Cry  
 Seizures Developmental Regression Other \_\_\_\_\_

Does your child receive annual flu shots? No Yes (informed decision) Yes (recommended by MD)  
 Has your child been exposed to antibiotics? No Yes  
 If yes, how many doses in past 6 months? \_\_\_\_\_ Reason \_\_\_\_\_  
 Were probiotics used at the same time as antibiotics? No Yes  
 Has your child been exposed to medications, including OTC: No Yes  
 If yes, which ones? \_\_\_\_\_  
 If yes, how many doses in past 6 months? \_\_\_\_\_ Reason \_\_\_\_\_

How many glasses of water/day does your child have? . . . . . 0 1-3 4-6 7-9 10+  
 How many glasses of cow's milk, juice and soda/day does your child have: . . 0 1-3 4-6 7-9 10+  
 Does your child eat gluten? . . . . . No Yes Trying to eliminate from diet  
 Does your child eat dairy? . . . . . No Yes Trying to eliminate from diet  
 Does your child eat refined sugars (white sugar), white bread and pasta? . . No Yes Trying to eliminate from diet  
 Does your child eat boxed/frozen foods? . . . . . No Yes Trying to eliminate from diet  
 Do you choose organic foods? No Yes If yes, which: Veggies Fruits Meats Grains All  
 Does your child eat any artificial sweeteners like Splenda, Aspartame, AminoSweet, Diet Soda? No Yes  
 Does your child follow any other dietary restrictions? No Yes \_\_\_\_\_  
 Any food/drink allergies, sensitivities, intolerances? No Yes \_\_\_\_\_  
 Is your child exposed to second hand smoke? No Yes \_\_\_\_\_  
 Does your child take a probiotic daily? No Yes: \_\_\_\_\_ CFU's/day  
 Does your child take vitamin D3 daily? No Yes: \_\_\_\_\_ IU's/day  
 Does your child take Omega 3 Fish Oils daily? No Yes: \_\_\_\_\_ mg/day Capsule Liquid  
 Other supplements or homeopathics? \_\_\_\_\_

## Goals & Consent

Do you feel your child is developmentally appropriate for their age:  
 Intellectually: Yes No \_\_\_\_\_  
 Emotionally: Yes No \_\_\_\_\_  
 Physically: Yes No \_\_\_\_\_

What is your primary goal for your child at our clinic? \_\_\_\_\_

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.

\_\_\_\_\_  
 Consenting Adult's Signature Date