



## 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: \_\_\_\_\_

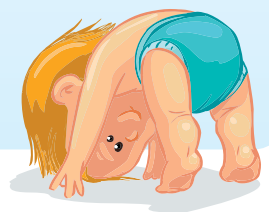
Name: \_\_\_\_\_

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? No Yes \_\_\_\_\_  
 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 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? \_\_\_\_\_

### Child Health History (Answer only those which are applicable)

How many hours does your baby sleep between feedings? \_\_\_\_\_ Day \_\_\_\_\_ Night  
 Does your child have a preferred sleeping position? No Yes \_\_\_\_\_  
 Does your child have any feeding difficulties? No Yes \_\_\_\_\_  
 Is your child currently being breast fed? Yes: exclusively breastfed formula supplemented No  
 If no, how long was the baby breast fed? \_\_\_\_\_ weeks/months  
 Does your child have a one-sided breast preference? No Yes If yes, Prefer Left or Right \_\_\_\_\_  
 Does your child frequently spit up after feeding? No Yes \_\_\_\_\_  
 Does your child cry often? No Yes If yes, approximately how many hours per day? \_\_\_\_\_  
 Does your child pass a lot of intestinal gas? No Yes \_\_\_\_\_  
 Does your child frequently arch his/her head and neck backwards? No Yes \_\_\_\_\_  
 Has your child shown any sensitivities to foods either in your diet or their own? No Yes \_\_\_\_\_  
 Is your child exposed to cow's milk/dairy? No Yes, formula Yes, directly Yes, I drink it and breastfeed.

### Developmental History

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 \_\_\_\_\_

