

Child's Name: _____ Date: _____

Child's DOB: _____ Age: _____ Child's Height: _____ Weight: _____

Sex: Male Female Parent/Guardian Name: _____

Home Address/Zip: _____

Parent's Cell Number: _____ Alt. Phone Number: _____

Parent's E-mail: _____ Appointment Reminders: Text Email

How did you hear about us? _____

Emergency Contact Name: _____ Relationship to Child: _____

Phone number: _____ Alt. Phone number: _____

Family Doctor Name & Clinic: _____

Prof. Designation: _____ Date/Reason of Last Visit: _____

Other Healthcare Professionals: Medical Specialist, Naturopathic Doctor, Counselor, etc.

Name: _____ Prof. Designation: _____

Date/Reason for last visit: _____

Name: _____ Prof. Designation: _____

Date & reason for last visit: _____

Has your child received previous chiropractic care? Yes No

Why have you decided to have your child evaluated by us?

- 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

Do you have a specific concern that brings you in?

- No - We want a nervous system and general wellness assessment for optimal health
- 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? _____

Who, if anyone else, have you seen regarding this complaint? _____

What treatment did they use? _____

Has your child taken any medication for this complaint? No Yes, If so which: _____

Has your child ever experienced this complaint before? No Yes

Did they receive any treatment at that time? No Yes Had x-rays taken for it? No Yes

What is your primary goal for your child at our clinic? _____

Symptoms and Health History

Current Previous	Current Previous	Current Previous
<input type="checkbox"/> Asthma	<input type="checkbox"/> Flatulence	<input type="checkbox"/> Failure to Thrive / Slow Weight Gain
<input type="checkbox"/> Respiratory Tract Infections	<input type="checkbox"/> Yeast Infections	<input type="checkbox"/> Slow/Absent Reflexes
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Asymmetrical Crawl/Gait
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Diabetes - Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2
<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Weight Challenges
<input type="checkbox"/> Strep Throat	<input type="checkbox"/> Anemia	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Thrush	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Sleep Problems
<input type="checkbox"/> Frequent Colds / Croup	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Night Terrors
<input type="checkbox"/> Recurrent Fevers	-How often: _____	<input type="checkbox"/> Tip Toe Walking
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Regression Milestones
<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Torticollis / Head Tilt	<input type="checkbox"/> Seizures
<input type="checkbox"/> Eczema	<input type="checkbox"/> Trouble Feeding on One Side	<input type="checkbox"/> Tremors / Shaking
<input type="checkbox"/> Rashes	<input type="checkbox"/> Back Pain	<input type="checkbox"/> ADD / ADHD
<input type="checkbox"/> Allergies	<input type="checkbox"/> Growing Pains	<input type="checkbox"/> Autism / PDD
<input type="checkbox"/> Allergy shots	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Psychiatric care
<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Red, Swollen, Painful Joint	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Colic	_____
<input type="checkbox"/> Constipation	<input type="checkbox"/> Frequent Crying Spells	_____

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? 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 Unsure

Yes - If yes, please describe: Breech Transverse Face / Brow presentation

Delivery was: Vaginal - If vaginal, was the baby presented: Head Face Breech

C-section - If a C-section: Planned Emergency

Interventions used during delivery, if any? 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? ____ Hrs

Length of second stage (pushing phase) of the labor? ____ Hrs

Any purple markings / bruising on baby's face or head at birth? No Yes

Any concerns about misshapen head at birth? No Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? ____ Wks ____ Days Birth weight ____ lbs ____ oz

Birth length: ____ inches If known, APGAR scores at: 1 minute ____/10 5 minutes ____/10

Any time spent in Neonatal Intensive Care? No Yes - If yes, for how long? _____ Why? _____

Was any medication given to the baby at birth? No Unsure Yes, the following medications and why: _____

Exclusively breastfed? No Yes, for ____ mos Breastfed + formula fed? No Yes, for ____ mos

Any sensitivities to formula (reflux, eczema, arching back, frequent spit up)? No Yes

Age solid foods introduced? ____ mos Was child introduced to cereal/grains in 1st year? No Yes

Did/Do you practice any attachment parenting methods: Kangaroo care Elimination communication

Cosleeping Feeding on demand Extended breastfeeding Other: _____

Significant time spent in any baby devices such as, bouncer seats, swings, bumbos, car seats, etc.)?

No Yes: _____

Physical Traumas

Has your child ever fallen from any high places? No Yes: _____

Has your child 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: _____

Lifestyle Factors

Child's frequency of tablet, computer or video games use: Never Rarely Daily Several hrs/day

Child's TV watching frequency: Never Rarely Daily Several hrs/day

Child's exercise frequency: Never Rarely Daily Several hrs/day

Does your child play contact sports? Never Rarely Daily Several hrs/day

Does your child sleep on their: Back Belly Sides (both, right, left)

Does your child carry a backpack? No Yes Approximate weight of backpack: _____ lbs

Do they wear their backpack 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

Has your child been vaccinated? No Yes, on a delayed or selective schedule Yes, on schedule

Reason for vaccination: Informed decision Unaware of choice to do so or not It was recommended

Reaction(s), if any, 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 taken antibiotics? No Yes - Doses in past 6 months: _____

Reason(s): _____ Were probiotics taken concurrently? No Yes

Any other medications taken, including OTC: No Yes: _____ For _____

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 Decreasing it in diet Not sure

Does your child eat dairy? No Yes Decreasing it in diet

Does your child eat refined sugars (white sugar), white bread and pasta? No Yes Decreasing in diet

Does your child eat boxed/frozen foods? No Yes Decreasing in diet Not sure

Does your child eat any artificial sweeteners like Splenda, Aspartame, Diet Soda? No Yes

Does your child follow any other dietary restrictions? No Yes: _____

Any food/drink allergies, sensitivities, intolerances? No Yes: _____

How much of your food is organic? None Some All

Is your child exposed to secondhand smoke? No Yes

Supplements/Other

Omega 3 Fish Oils? No Yes _____ mg/day Caps Liqui

Does your child take: Vitamin D3? No Yes, _____ IU's/day Probiotics? No Yes, _____ CFU's/day

Other supplements or homeopathics? _____

Do you feel your child is developmentally appropriate for their age:

Intellectually: Yes No

Emotionally: Yes No

Physically: Yes No