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Practice Member Information

File

Form fields for child's name, parent/guardian names, address, phone numbers, email, and consent information.

Emergency Contact

Form fields for emergency contact name, relationship, and phone numbers.

Family Doctor

Form fields for family doctor name, professional designation, clinic name, and date of last visit.

Other Health Care Professionals

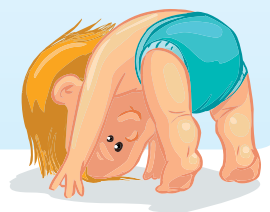
(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, Massage Therapist, etc)

Form fields for other health care professional name, designation, and date of last visit.

Form fields for other health care professional name, designation, and date 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 _____

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 Welp 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.

_____ Date