PERSONAL INFORAMTION

Name:_____ Date:_____
Birthday:_____ Age:_____ Gender F☐ M☐
Address:_____
City:_____ Zip Code:_____
Home #_____Cell #:_____Work#:_____
E-mail Address:_____
Mother's name:_____ Father's name:_____
Sibling_____ Age:_____ Gender F☐ M☐
Sibling_____ Age:_____ Gender F☐ M☐

Who may we thank for referring you to out office? or how did you choose us?

☐Family/ Friend (name)_____☐Health Practitioner:_____
☐Website ☐Facebook ☐Walk-in ☐Other:_____

CHIROPRACTIC HISTORY

Has your child been to a chiropractor before? ☐No ☐Yes, Date of last visit _____
Has a family member previously seen a chiropractor? ☐No ☐Yes, Parent_____Sibling_____
Name of Chiropractor:_____
Reason for seeing them:_____
Describe your experience:_____
How frequently did you go for adjustment?_____
What made you decide not to return to see them?_____

PREGNANCY HISTORY

Were any supplement taken during the pregnancy ? ☐No ☐Yes_____
Medication taken during pregnancy (amniocentesis, CVS, etc.) ☐No ☐Yes
If yes, Please explain:_____
Trauma/illness during pregnancy:_____
Please describe any emotional stress the mother experience during the pregnancy:_____
_____

IMPORTANT NOTE:

Today's visit will be focusing on assessing the health of your spine and nerves system. Your central nervous system (brain and spinal cord) is the master controller of your body. Everything in your life is processed and controlled by your nervous system, therefore your health and overall quality of life is depended on proper function and communication. Due to the close relationship with your spine, if your spine is misaligned and degenerating, it can interfere and alter the function of your nervous system (SUBLUXATION). The results of this miscommunication between your brain and body in some cases is pain or discomfort but it can have broader, more serious effects such as energy loss, fatigue, depression, immune problems, digestive problems, high blood pressure and many more. Many times subluxations are affecting your health long before symptoms show up. By continuing to fill out this form, we will understand how subluxations may already be affecting your health and quality of life.

LABOUR AND BIRTH HISTORY

Position during labour: ☐On back ☐Side ☐Sitting ☐Standing

Was labour induced? ☐No ☐Yes Reason?_____

Did the mother have an episiotomy? ☐No ☐Yes

Was monitoring used? ☐Internal ☐External

Location of birth? ☐Home ☐Hospital ☐Birthing center

Birth assistants? ☐Midwife ☐Doula ☐Medical doctor ☐None

Was the mother administered any drugs? ☐Epidural ☐Morphine ☐Other:_____

Was there any intervention used during birth?

☐No ☐Yes ☐Forceps ☐C-section ☐Vacuum

How many hours did labour last?_____Birth weight:_____ Birth length:_____

Was there any evidence of birth trauma to the infant? Check all that apply:

☐Bruising ☐Stuck in birth canal ☐Respiratory depression

☐Odd shaped head ☐Fast or excessively long birth ☐Cord around neck

Were there any other complications during birth or Congenital anomalies/ defects present?

☐No ☐Yes; If yes, Please explain:_____

MEDICAL HISTORY

Has your child been vaccinated? ☐No ☐Yes ☐Partial ☐Alternate schedule ☐Homeopathic

Did you notice any negative reaction? ☐No ☐Yes _____

History of antibiotics? ☐No ☐Yes , Reason?_____

Which ones and how many rounds?

Has your child taken prescription medications ? ☐No ☐Yes , Reason?_____

Which ones and how many time?_____

Has your child taken over-the-counter medications ? ☐No ☐Yes , Reason?_____

Which ones and how many times?_____

GROWTH AND DEVELOPMENT

Was child breast-fed? ☐No ☐Yes For how long?_____

Difficulties with lactation: ☐No ☐Yes If yes,_____

Was formula introduced? ☐No ☐Yes Reason?_____

Was cow's milk introduced? ☐No ☐Yes At what age?_____

Have solid foods been introduced? ☐No ☐Yes At what age?_____

1st foods_____

Food intolerance?_____

Quality of sleep: ☐Good ☐Fair ☐Poor Number of hours:_____

Did your child favor turning their head to one side while sitting, sleeping or nursing?

☐No ☐Yes ☐Left ☐Right

At what age did your child start: Roll over_____ Crawl:_____ Walk:_____
Describe any complications or delays with motor development:_____
Any complications or delays noticed with speech development:_____
Any falls from couches, bed, change tables, etc…? ☐No ☐ Yes

HEALTH CONCERNS- FILL IN ALL AREAS Please check ☑ all that you have experienced in the last 12 months

☐ ADD/ ADHD	☐Constipation/Gas	☐G.I Issues	☐Swollen tonsils
☐ Allergies_____	☐Cramps	☐Hip Dysplasia	☐Torticollis
☐ Anxiety	☐Depression	☐Headaches/Migraines	☐Reproductive issues
☐ Asthma	☐Diabetes	☐Heart Disease	☐Urinary tract infection
☐Autism	☐Diarrhea	☐Hernias	☐Vision/Hearing Loss
☐Back pain	☐Dizziness	☐Neck/Shoulder Pain	☐Walking development
☐Balance ☐Coordination	☐Ear Infections/Aches	☐Plagiocephaly/odd head shape	
☐Bedwetting	☐Eczema	☐Pneumonia/Bronchitis	☐Tinnitus/Ringing Ears
☐Behavior issues	☐Epilepsy/Seizure	☐Respiratory issues	☐Other:_____
☐Cancer	☐Feeding difficulty	☐Sensory Processing	
☐Colic	☐Focus/Memory Issues	☐Skin issues	
☐Fever	☐G.I Issues	☐Sleep difficulty	
☐Food Sensitivities	☐Hip Dysplasia	☐Speech issues	

Fill out ALL details below for the 3 most concerning conditions that you checked off:

1. _____
On a scale of 1-10 (10 being severe), how bad is the problem? _____/10
When did it start?_____ How ?_____
Is it? ☐Getting better ☐Getting worse ☐Staying the same
How would you describe the problem?_____
Are you taking medications for this condition? No☐ Yes☐ Please list:_____

2. _____
On a scale of 1-10 (10 being severe), how bad is the problem? _____/10
When did it start?_____ How ?_____
Is it? ☐Getting better ☐Getting worse ☐Staying the same
How would you describe the problem?_____
Are you taking medications for this condition? No☐ Yes☐ Please list:_____

3. _____
On a scale of 1-10 (10 being severe), how bad is the problem? _____/10
When did it start?_____ How ?_____
Is it? ☐Getting better ☐Getting worse ☐Staying the same
How would you describe the problem?_____
Are you taking medications for this condition? No☐ Yes☐ Please list:_____

Special Note: Have you taken any medication within the last 24 hours? No☐ Yes☐

Please list:_____

What parts of life is this interfering with ☐School ☐Sleep ☐Play ☐Hobbies ☐Exercise ☐Family ☐Social ☐Positive mental attitude ☐Other:_____

Which part of life is most important to get back ASAP?_____

Beyond feeling better, what are 3 reasons you want to be healthier?

1. _____
2. _____
3. _____

Informed Consent

Chiropractic care has been proven to be safe, both clinically and scientifically. The risk of injuries and complication is so small that Chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Although Chiropractic is reported to be the safest health care system in the world, there are a few "side effects" associated with it and we feel that it is responsible to let you know:

1. Research show that the most common unpleasant effect following chiropractic care is temporary muscle soreness associated with the adaptive changes after the adjustment. This however is only temporary and generally not severe soreness.
2. While extremely rare, there have been reports of ligament sprains and rib fractures.

☐ I have read and understand the above consent. If I have any questions or concerns, I will discuss them with my Chiropractor.

☐ I understand that research and training is an important aspect for all health care disciplines. For this reason, I consent to my information being used for research data purposes and understand that audio or video recordings may occur from time to time. (Your personal privacy is very important to us. We will not release any personal information).

☐ I consent to the care recommended by my Chiropractor and extend this consent to include all other Chiropractors in this office

Child's name: _____ Parent/ Guardian:_____

Signature:_____ Witness:_____ Date:_____