new life CHIROPRACTIC

Child's Last Name: ______________________First:_________________ Sex: M / F , Birth Date:___/___/___
Parents Name:____Today's Date_____/_____/_____
Who may we Thank for referring you to our office?____

Your Child's Health Profile

Why This Form Is Important

As a traditional (wellness) Chiropractic office, we focus on your ability to be healthy. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Children are very sensitive to the stress parents have and this causes stress in them. Most times the effects are gradual not even seen until they become serious. Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Answering the following questions will give us a profile of the specific stresses your child has faced, allowing us to better assess the challenges to your child's health potential.

If your child has no symptoms or complaints and are here for wellness services, please check (√) here ☐ Others need to describe the major complaints, how and when did it start? Including the effect it has had on you and your child's life.

Please rate 0-10 with 10 being the worst.

1.____0-10 =______
____
____

2.____0-10 =______
____
____

3.____0-10 =______
____
____

4.____0-10 =______
____

What makes it better: 1____________________________________2____________________________________
3____________________________________4____________________________________
What makes it worse: 1____________________________________ 2 ____________________________________
3____________________________________4____________________________________
Previous Chiropractic care ___________________Date of last visit____/____/____Reason:_______________________
Name of Pediatrician:__________________ Date of last visit____/____/____Reason:_______________________
Number of Doses of Antibiotics Your Child Has Taken: _______List:_______________________________
Number of Doses of Prescription Medication Your Child Has Taken: _______List:_______________________________
Number of Doses of Non-Prescription Medication Your Child Has Taken: _______List:_______________________________
Current Medications:___________________________ Vitamines/Supplyments: ___________________________
Hospital/Emergency Room visits:______________________ Prior Surgery:_______________________________
Other Doctors Seen for this Condition ☐NO ☐YES, Doctors' Names and Prior Treatment:_________________________
____
Other Health Problems:____

PRENATAL HISTORY: Complications During Pregnancy: ☐Toxemia ☐Diabetes ☐Morning Sickness ☐Heartburn ☐Back Pain ☐Headaches ☐Other, **Mothers' Health/Nutrition** ☐Poor ☐Good ☐Excellent, **Stress During Pregnancy:** Please rate 0-10 with 10 being the most. ______
Family History Of: Diabetes, Heart/Cardiovascular Problems, Other anomalies:___________________________
Falls/Injuries/Accidents During Pregnancy:___________________ Complication During Delivery: ☐No ☐Yes, ☐C-Section ☐Vacuum/Forceps ☐Induced ☐Epidural ☐Fetal distress ☐Meconium, **Oxygen** ☐no ☐yes_______ **ICU** ☐no ☐yes____

BIRTH INJURIES: Bumps/Bruises/Swelling____________ Broken Bones____________ Other___________________

FEEDING HISTORY: Food/Juice Allergies or Intolerances: ☐No ☐Yes, List: ______________________________
Do you have any concerns about your child's diet? ____
What does your child eat for breakfast? ____

new life CHIROPRACTIC

What does your child eat for lunch? ____

What does your child eat for dinner? ____

What does your child eat for snacks? ________________________________Favorite food________________________

What fast food does your child eat? ____Times/week __________

How much water does your child drink ________cups/day, How much juice does your child drink ________cups/day,

How much soda pop does your child drink _______cups/day, # of bowel movements each day__________________

Has your child fallen from a bike, skateboard, scooter, rollerblades or similar. ☐No ☐Yes Has your child fallen down stairs or from a height greater than 3 feet ☐No ☐Yes Has your child ever been in a motor vehicle accident or near-miss ☐No ☐Yes, Number of hours watching TV/day______, Hours spent at the computer/video games /day______, How heavy is their backpack/schoolbag ____,

What sports/activities does the child do____,

Vaccines: ☐No ☐Yes, ☐Partial ☐Complete **Reactions:** (Fever, Fussy, Ect.) ☐Slight ☐Mild ☐Severe

Describe reactions:____,

Check any of the following that your child has suffered from: ☐Falls________________ ☐Car Accident__________________

☐Ear Infections_____________________	☐Asthma___________________________	☐Bed Wetting______________________
☐Digestive Difficulties________________	☐Recurrent Fevers____________________	☐Frequent Colds____________________
☐Seizures__________________________	☐Tremors___________________________	☐Sleep Problems____________________
☐Allergies__________________________	☐Head Tilt__________________________	☐Feeding Difficulties_________________
☐Rashes/ Dry skin____________________	☐Foot/Hip/Leg Problems_______________	☐Hand/Arm/Shoulder Problems__________
☐Difficulties Breathing________________	☐Growing Pains______________________	☐Weight Loss/Poor Weight Gain_________
☐Constipation/Diarrhea________________	☐Spitting Up/Vomiting_________________	☐Dislocated a Joint__________________
☐Excessive Gas______________________	☐Head Banging or Headaches___________	☐Broken/Fractured a Bone_____________
☐Kidney/Bladder Problems_____________	☐Heart Conditions ____________________	☐Hernias__________________________
☐Vision Problems____________________	☐Hearing Problems____________________	☐Co-ordination Problems______________
☐Postural Problems___________________	☐Attention/Hyperactivity_______________	☐Nightmares_______________________
☐Reading/ Learning Difficulties__________	☐Respiratory Infections________________	☐Trouble Walking /Running ____________

The following 3 areas can contribute to nerve interference and malfunction and diminish quality of life. Circle the areas that apply to you r child: **Y=Yes N=No or Never had (please circle)**

Physical Stress			**Emotional Stress**			**Chemical Stress**		
Slip/Fall / Sport Injury	Y	N	Family	Y	N	Second Hand Smoke	Y	N
Poor Posture	Y	N	Hold Feelings In	Y	N	Sugar/Carbs/Sweeteners	Y	N
Lack of Physical Activity	Y	N	Quick Temper	Y	N	Poor Diet	Y	N

TERMS OF SERVICE When a person seeks chiropractic care and we accept someone for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. We also strive to inform you how minimize or manage physical, chemical and emotional stress that creates the subluxations.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine and extremities.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate wisdom/ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend you seek the services of a health care provider who specializes in that area. Regardless of what disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. If a lifetime of a better functioning body is what you want for you, your family, and friends, then welcome! You are in the right place.

I, (Printed name)____ (Signature)__________________________________undertake chiropractic services on the understanding of and agreement with, the above explanation. ________________ (Date).

Consent to evaluate and adjust a minor and/or child: I, ____ (Print name) being the parent or legal guardian of ______________________________________(Print name) give permission for my child to receive chiropractic care.