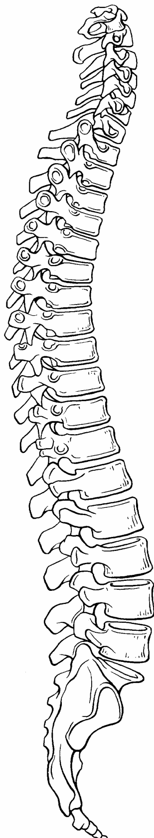
About Your Child…

Welcome to our office! It is well known that families who maintain strong healthy, well-aligned spines have much improved health. People whose spines are not kept in proper alignment are much more likely to develop health disorders later in life such as arthritis, illness, pain, heart attacks, strokes, even cancer.

Our purpose is to care for and educate as many families as possible towards optimal health. Spinal subluxation destroys an optimal spine and your ability to have optimal health. Your experience with this office will not just be of healing but also of learning about optimal health and healing.



Child's Name ____ Home Phone ________________________

Mother's Name: ________________ Father's Name: ________________ Marital Status: ________________

Address ______________________________________ Cell Phone ________________________________

City, State, Zip ____

Birth date _____________________ Age _________ Grade ______________________________________

E-Mail Address ____

1. Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend/Family Member Name ________________________________

☐ Telephone Call ☐ Yellow Pages ☐ Sign ☐ Website ☐ Presentation ☐ E-mail

2. Research shows that spinal problems often begin at birth. How old was your child when they received their first chiropractic checkup? ________ ☐ Never

3. Difficult, long and/or doctor-assisted births can cause spinal misalignments. Was your child born by C-section, forceps, suction cup or other device? (Please circle) ☐ YES ☐ NO

4. How long was the actual labor and delivery time? ____

During the birth, did the mother have any epidural or receive any medication?

☐ YES ☐ NO Comments ____

5. Have you ever been told that your child has a spinal curvature, spinal arthritis, or inherited spinal problem? ☐ YES ☐ NO ____

6. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your child's posture? Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

7. Did your child have early health challenges such as colic or frequent ear infections? ☐YES ☐NO

8. Does your child suffer from any of the following: allergies, sinus problems, bed-wetting, difficulty concentrating, attention deficit disorder? (Please circle)

9. Please list any health symptoms or health complaints your child is experiencing.

1. __________________________ 2. _________________________ 3. __________________________

10. What is your motivation to seek/receive care in this office for your child?

____

11. Do you miss work or sleep often due to your child's illnesses? ☐ YES ☐ NO

12. Do you worry often about your child's health? ☐ YES ☐ NO

13. Do you any have health problems that affect your family? Please list ______________________

____

14. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications is your child currently taking?

____

15. Falls, sports impacts and auto accidents can cause serious spinal problems. Is this visit related to an auto accident or injury? ☐ YES ☐ NO Date of Incident ____________________

16. If the doctor feels that your child will benefit from chiropractic care are you willing to follow his/her recommendations? ☐ YES ☐ NO

16. Would you like to receive our weekly health and wellness newsletter via e-mail? ☐ YES ☐ NO

(OVER)

Physical Trauma

Has the child had any: Falls Car accidents Sport injuries Broken bones

Is your child involved in any athletic activities or extra-curricular activities? ☐ YES ☐ NO

Do/did you notice any position in which your child seems uncomfortable? ☐ YES ☐ NO

Does your child have tubes in the ears? ☐ YES ☐ NO If yes, at what age where they put in? ________

Has your child had any other surgery? ☐ YES ☐ NO

Comments ____

____

Emotional/Mental Trauma

Please circle any of the following emotional/mental stresses that the child has experienced:

Illness Parent's divorce School Abuse Loss of loved one Family

Does your child express emotion easily? ☐ YES ☐ NO

Does your child have any difficulty sleeping? ☐ YES ☐ NO

Does your child have unusual crying spells? ☐ YES ☐ NO

Comments____

____

Chemical Trauma

What is your child's diet like? Please Describe____

Your child predominately drinks: Soda Juice Bottled/filtered water Tap Water Caffeinated drinks Milk

Does your child use fluoride toothpaste? ☐ YES ☐ NO

Has your child been vaccinated? ☐ YES ☐ NO

If yes, were there any reactions to the vaccinations? ☐ YES ☐ NO Please Explain___________________________

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, downstairs, etc.) Was this the case with your child? ☐ YES ☐ NO

Comments

____

____

Are there particular cartoon characters, figures, or names which create rapport with your child? ______________________

The above information is true and accurate to the best of my knowledge.

Signature of Parent or Guardian____Date___________________

We thank you for allowing us the privilege of being an integral part of your child's health and well being. We consider this the utmost expression of faith and will give your child the highest degree of clinical excellence that we can provide.