Child's Name: _____DOB: _____ Date: _____
Parent's/Guardian's Name: _____
Home Address: _____
Home Phone: _____ May we leave a message? ☐ Yes ☐ No
Parent's Cell Phone: _____ May we leave a message? ☐ Yes ☐ No
Parent's E-mail: _____
How did you hear about us? _____
Siblings and ages: _____
Previous Chiropractic Care? ☐ Yes ☐ No

**Emergency Contact**
Name: _____Relationship to child: _____
Phone Number: _____ Alternative Phone Number: _____

**Why have you decided to have your child evaluated by a Chiropractor?**
☐ He/She is continuing 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.

**Post Natal & Infant History**
How many weeks gestation was the baby at birth? _____ Weight: _____ Length: _____
Was the baby ever admitted to the NICU? ☐No ☐Yes
If yes, for how long and why? _____
Was any medication given to the child at birth? ☐No ☐Yes ☐Unsure
If yes, what medication any why? _____
Was your child exclusively breastfed? ☐No ☐Yes ☐Months: _____
Was your child breastfed + formula fed? ☐No ☐Yes ☐Months: _____
Did your child show any sensitivities to formula (reflux, eczema, arching back)? ☐No ☐Yes
Did you introduce cereal or grains within your child's first year? ☐No ☐Yes
Did your child spend a lot of time in any baby devices (bouncy seats, swings, bumbos, car seats, etc.?)
☐No ☐Yes Which ones? _____

**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 – a condition called 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 Refluxes |
| ☐ | ☐ | 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 | ☐ | ☐ | Sensory Processing Issues |
| ☐ | ☐ | Rashes | ☐ | ☐ | Scoliosis | ☐ | ☐ | Seizures |
| ☐ | ☐ | Allergies | ☐ | ☐ | Red, Swollen, Painful Joint | ☐ | ☐ | Tremors / Shaking |
| ☐ | ☐ | Food Sensitivities | ☐ | ☐ | Colic | ☐ | ☐ | ADD / ADHD |
| ☐ | ☐ | Digestive Problems | ☐ | ☐ | Frequent Crying Spells | ☐ | ☐ | Autism / PPD |

Do you have a specific concern that brings you in?

☐No, I would like my child's nervous system assessed to achieve optimal health & functioning.

☐Yes: _____

*If yes, please answer the following questions:*

Does your child appear to be in pain in discomfort? _____ For how long? _____

Is it getting better, worse, or staying the same? _____ Suddenly or gradually? _____

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:

Has your child had x-rays in relation to the current complaint? ☐No ☐Yes:

Has your child had any blood work done for the current complaint? ☐No ☐Yes:

**Birth Experience**

Location of Birth: ☐Home ☐Hospital ☐Birthing Center ☐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 any time during pregnancy in a constrained position? ☐No ☐Yes ☐Unsure

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

Was your delivery vaginal or C-section? _____ If 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? ☐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

**Physical Traumas**

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

Has your child ever been involved in a motor vehicle accident? ☐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 _____

Does your child use a tablet, computer, or video game? ☐Never ☐Rarely ☐Daily ☐Several hrs/day

Does your child watch TV? ☐Never ☐Rarely ☐Daily ☐Several hrs/day

Does your child exercise? ☐No ☐Daily ☐Weekly ☐Seasonally

Does your child play contact sports? ☐No ☐Daily ☐Weekly ☐Seasonally

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

Does your child carry a back pack? ☐No ☐Yes

Does it weigh less than 15% of their body weight? ☐No ☐Yes

Do they wear their back pack on 2 shoulders? ☐No ☐Yes

Do your child's shoes show excessive or uneven wearing out? ☐No ☐Yes

Does your child wear custom orthotics?

☐No ☐Yes, for what purpose? _____

**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 office? _____

Our goals are to provide a detailed assessment of your child's current 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, and physical examination. Any findings will be communicated before consenting to commencement of treatment, if appropriate.

_____ _____

Consenting Adult's Signature Date