

Events and Habits

NEONATAL TO NOW: Many problems have their roots in early spinal and/or neurological damage.

Yes	No		Patient Comments
		BIRTH	
<input type="checkbox"/>	<input type="checkbox"/>	Was it a vaginal birth?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Assisted birth (forceps/vacuum extraction/c-section)?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mother given medication prior or during delivery?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Complications at birth?	_____
		GROWTH AND DEVELOPMENT	
<input type="checkbox"/>	<input type="checkbox"/>	Developmental milestones met on time?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping patterns seem "normal"?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Any surgeries or prolonged medications?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Any notable falls/injuries?	_____
		CHEMICAL STRESSORS	
<input type="checkbox"/>	<input type="checkbox"/>	Breast-fed? How long?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Formula introduced at age _____	
<input type="checkbox"/>	<input type="checkbox"/>	Introduced cow's milk at age _____	
<input type="checkbox"/>	<input type="checkbox"/>	Food/juice intolerance? Type: _____	
		Began solid foods at age _____	
<input type="checkbox"/>	<input type="checkbox"/>	Picky eater? _____	
<input type="checkbox"/>	<input type="checkbox"/>	Did the mother smoke during pregnancy?	
<input type="checkbox"/>	<input type="checkbox"/>	Illness of the mother during pregnancy? _____	
<input type="checkbox"/>	<input type="checkbox"/>	Supplements/drugs during pregnancy? _____	
<input type="checkbox"/>	<input type="checkbox"/>	Drugs during pregnancy: _____	
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to ultrasound? How many and when? _____	
<input type="checkbox"/>	<input type="checkbox"/>	Invasive procedures (amniocentesis, CVS) _____	
<input type="checkbox"/>	<input type="checkbox"/>	Any pets at home? _____	
<input type="checkbox"/>	<input type="checkbox"/>	Any smokers at home? How much? _____	
<input type="checkbox"/>	<input type="checkbox"/>	Vaccinations: Which ones and any reactions? _____	
<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics? Number of courses to date? _____	
		PSYCHOSOCIAL STRESSORS	
<input type="checkbox"/>	<input type="checkbox"/>	Difficulties with lactation?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Problems bonding?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Behavioural problems? Onset?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Daycare? Age started?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Night terrors/sleep walking?	_____
		Sleep posture: <input type="checkbox"/> Side <input type="checkbox"/> Back <input type="checkbox"/> Stomach	
		Average number of hours of television/computer/week	_____

Yes	No	TRAUMATIC STRESSORS	
<input type="checkbox"/>	<input type="checkbox"/>	Traumas during pregnancy (falls, accidents)?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was your child ever in a motor vehicle accident?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Notable falls/injuries?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Any hospitalizations?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Any surgeries?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Any head injuries/broken bones?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sports played? Began at age: _____ Hours/week played? _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Backpack weight seems excessive?	_____

Symptoms and Ill Health

As the years go by and the layers of damage to your child's spine and nervous system increase, it is common to begin experiencing symptoms and have random bouts of ill health until they are brought to their present state of health.

Reason for consulting our office: _____

What do you hope to gain from care at this office? _____

If you have a specific concern, please describe briefly. If no, please proceed to next page.

How and when did this problem start? _____

Is the problem ...	<input type="checkbox"/> constant	<input type="checkbox"/> intermittent	<input type="checkbox"/> no change
Is the condition worse ...	<input type="checkbox"/> in the A.M.	<input type="checkbox"/> in the P.M.	<input type="checkbox"/> worse with movement
Is it interfering with ...	<input type="checkbox"/> sleep	<input type="checkbox"/> daily routine	
	<input type="checkbox"/> other _____		

Is condition getting progressively worse? Yes No

Have X-rays, MRI or CAT been taken of the area? Yes No When? _____

Have any of the following been tried to solve the problem?

<input type="checkbox"/> Ice	<input type="checkbox"/> Heat	<input type="checkbox"/> Stretching/exercise	<input type="checkbox"/> Vitamins
<input type="checkbox"/> Medications	<input type="checkbox"/> Rubs or gels	<input type="checkbox"/> Diet changes	<input type="checkbox"/> Stress reduction
<input type="checkbox"/> Aspirin or Tylenol	<input type="checkbox"/> Surgery	<input type="checkbox"/> Chiropractic care	<input type="checkbox"/> Massage/Body work
<input type="checkbox"/> Naturopathic care	<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Other: _____	

Has your child ever or do they presently suffer from any of the following symptoms?

Past	Now		Past	Now	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	Nose/sinus problems
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/balance issues
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/lung problems
<input type="checkbox"/>	<input type="checkbox"/>	Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Tension
<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nausea
<input type="checkbox"/>	<input type="checkbox"/>	Cold feet/hands	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems
<input type="checkbox"/>	<input type="checkbox"/>	Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Digestive disorders	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems
<input type="checkbox"/>	<input type="checkbox"/>	Numbness or pins & needles in arms/legs			
<input type="checkbox"/>	<input type="checkbox"/>	Other? _____			

Is your child currently taking any medications or treatments? Do they experience any side effects from these medications/treatment? Please describe.

FAMILY HISTORY: (include parents & siblings)

Does any other family member experience any of the above listed symptoms? Yes No

If yes, which ones? _____

	Heart Disease	Stroke	Cancer	Arthritis	Diabetes	Other _____
Father's Side	<input type="checkbox"/>					
Mother's Side	<input type="checkbox"/>					
Siblings	<input type="checkbox"/>					

*Chiropractic provides three types of care. The first is **Initial Intensive Care**, which corrects the most recent layer of Spinal and Neurological damage. This care usually reduces or eliminates the symptoms. Then **Corrective Care** begins, which corrects the years of damage that occurred when there were few symptoms. And finally, chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your child's report of findings. Then you'll be able to begin a course of care that fits your health goals.*

I understand that the purpose of today's visit is to determine if your child is a candidate for chiropractic care. I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature: _____