Confidential Child Information

Name of Child: ______________________________ Date: ______________
Name of Child's Parent/Guardian: ______________________________
Name of Siblings and Ages: ______________________________
Address: ______________________________
Residence/Mailing City State Zip Code
Home Phone #: ______________ Parent/Guardian Work Phone #: ______________ Male Female
Email Address: ______________________ Date of Birth: ______________

Who may we thank for referring you to our office? ______________________
What are your objectives in consulting this office? Wellness Preventative Care Other: ______________
If you'd like us to check if you have insurance coverage, please let us know.

Your Child's Health Profile

Why is this form important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved heath potential and wellness services. On a daily basis we experience, physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

History

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. Please provide the following information on your child's history to the best of your ability.

Maternal History:

Did you work during your pregnancy? Please explain. ______________________________

____

Did you exercise regularly during your pregnancy? How much? ______________________________

____

Did you take any prescription drugs or over the counter drugs including infertility drugs? ______________

____

____

Did you take any vitamins or herbs? ______________________________

____

Did you smoke during this pregnancy? Y N How much? ______________________________
Did you experienced any of the following during your pregnancy?

- ☐ Spotting or bleeding ☐ Vomiting ☐ Bladder Infection ☐ Heart Burn
- ☐ Yeast Infection ☐ Neck pain ☐ Hemorrhoids ☐ Varicose Veins
- ☐ Low Back Pain ☐ Sciatica ☐ Headaches ☐ Midback or Rib Pain
- ☐ Numb Hands ☐ Hip Pain ☐ Severe Morning Sickness

Labor and Delivery:
Birth Weight: ______________ Current Weight: ______________
Birth Length: ______________ Current Height: ______________
Obstetrician/Midwife: ______________________________
Type of Birth: Vaginal Forceps Vacuum Extraction Caesarian
Location of Birth: Home Birthing Center Hospital
Please describe your delivery: ______________________________

____

____

Breastfed until: ______________ Any difficulty breastfeeding? ______________

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

If you have no symptoms or complaints, and are here for wellness services, please check here ____ "Wish to have Chiropractic Wellness Services". Otherwise, please briefly describe your health challenge including the effect it has had on your life.

Other doctors I've seen for this problem:

Chiropractor ____________________________

Medical Doctor ___________________________

Other ___________________________________

Please check all symptoms your child has ever had:

☐ Headaches	☐ Heartburn or Ulcers	☐ Sleeping problems	☐ ADD/ADHD
☐ Constipation/Colic	☐ Bedwetting	☐ Diarrhea	☐ Asthma
☐ Allergies	☐ Diabetes	☐ Ear Infections	☐ Skin Disorder
☐ Abdominal Abnormalities	☐ Neurological Abnormalities	☐ Heart or Lung Problems	☐ Torticollis

List any medications your child has taken:

____

____

Has your Child ever been treated on an emergency basis? ____

____

Pediatrician/Family MD:___________________________

What vaccinations has your child had, if any?

HEP B Date:___________ Reactions:____

DPT Date:___________ Reactions:____

PCV Date:___________ Reactions:____

HIB Date:___________ Reactions:____

MMR Date:___________ Reactions:____

VAR Date:___________ Reactions:____

Childhood Illnesses:____

____

Surgeries, Medications, Accidents: ____

____

Are there any other significant health/environmental/family issues relative to this child? ______________________________

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Siblings ____

Mother ____

Father ____

Other ____

Have you ever been to a chiropractor before? Yes No How often? ________ Doctor's name? ______________________

Have you ever been to a doctor who put you on a health development plan? Yes No I don't know

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation. I certify that the information on this form is true to the best of my knowledge.

____

Parent/Guardians Signature ***Please Print Name*** ***Date***