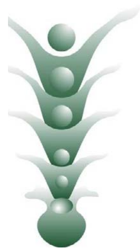

Saltash Chiropractic Clinic

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Pediatric
School Aged Children

Practice Member Information ______________________ File ____________

Child's Name: ______________________ M______ D ______ Y ______
Parent's/Guardian's Names: ______________________
Home Address: ______________________
City ______________________ State ____________ Zip ________
Home Phone: ______________________ May we leave a message? Yes No
Parent's Cell Phone: ______________________ May we leave a message? Yes No
Parent's Work Phone: ______________________ May we leave a message? Yes No
Parent's Email: ______________________
May we add you to our email newsletter and calendar of events? Yes No (Your email will not be shared)
How did you hear about us? ______________________
Height (of child): ______ Weight (of child): _____ Birth Date: M _____D _____Y _______Age:____ Sex: M F
Siblings and ages: ____________ ____________ ____________ ____________
Previous Chiropractic Care? Yes No

Emergency Contact

Name: ______________________ Relationship to child: ______________________
Phone number: ______________________ Alternate phone number: ______________________

Family Doctor

Name: ______________________ Professional Designation: ______________________
Clinic Name: ______________________ Date and reason of last visit: ______________________
May we communicate with your family doctor regarding your child's care if necessary? Yes No

Other Health Care Professionals

(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, Massage Therapist, etc)

Name: ______________________
Professional Designation: ______________________
Date and reason of last visit: ______________________

Name: ______________________
Professional Designation: ______________________
Date and reason of last visit: ______________________

Why have you decided to have your child evaluated by a Chiropractor?

He/She is continuing ongoing 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.

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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 in a condition called ***Vertebral Subluxation.*** Please answer the following questions to give us a better understanding 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 Reflexes
		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			Regression of Milestones
		Rashes			Scoliosis			Seizures
		Allergies			Red, Swollen, Painful Joint			Tremors / Shaking
		Food Sensitivites			Colic			ADD / ADHD
		Digestive Problems			Frequent Crying Spells			Autism / PDD

Do you have a specific concern that brings you in?
No, I'm interested in having my child's nervous system assessed to achieve optimal health and functioning.
Yes:____

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort?________ How long has your child been experiencing this?_______
Is it getting better, worse or staying the same?__________ Was the onset sudden or gradual? __________
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 __________________
Did they receive any treatment at the time? . . . . No Yes __________________
Has your child had x-rays in relation to the current complaint? . . No Yes __________________

Prenatal Profile

Adopted Prenatal history unknown Birth history unknown
Complications during pregnancy: No Yes (Brief description) ________________________
Ultrasounds during pregnancy: No Yes, if so, how many? ___ ________________________
Medications during pregnancy: No Yes______________________________
If so which ones and how often? (include OTC): ________________________
Exposure to alcohol, cigarettes or second hand smoke during pregnancy: No Yes __________________

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Birth Experience

Location of Birth: Home Hospital Birthing Centre 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 anytime during your pregnancy in an intra-uterine constraining position? No Yes Unsure
If yes, please describe: Breech Transverse Face / Brow presentation
Was your delivery vaginal or C-section?__________ If it was a 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 during delivery? Forceps Vacuum Extraction Other
Were there any complications during delivery? Yes No
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

Post Natal & Infant History

How many weeks gestation was the baby at birth? ___w ___d / Birth Weight: ___lbs___oz / Birth Length: ____Inches
If known, APGAR scores at: 1 minute_______ /10 5 minutes _______ /10
Was the baby ever administered to Neonatal Intensive Care? No Yes
If yes, for how long and why? ____________________
Was any medication given to the baby at birth? Yes No Unsure
If yes, what medication and 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, frequent spit up)? No Yes
What age did you introduce solid foods to your child? ______ months
Did you introduce cereal or grains within your child's first year? No Yes
Did/Do you practice attachment parenting methods:
(cosleeping, kangaroo care, elimination communication, feeding on demand, extended breastfeeding etc) No Yes
Did your child spend excess time in any baby devices such as: bouncer seats, swings, bumbos, car seats etc?
No Yes, Which ones?____________________

Physical Traumas

Has your child ever fallen from any high places?		No	Yes__________	
Has your child ever been involved in a motor vehicle accident or near miss?		No	Yes__________	
Has your child been seen on an emergency basis?		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 spend time using a tablet, computer or video games?	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 back?	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	Sometimes	
Does your child show excessive or uneven shoe wearing out?	No	Yes		

Does your child wear custom orthotics?
No Yes, For what purpose? ____________________

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Pediatric
School Aged Children

Chemical Stressors

Have you chosen to vaccinate your child? No Yes, on a delayed or selective schedule Yes, on schedule
Reason for vaccination: Informed decision Didn't know I had a choice It was recommended
Reaction(s) to vaccination: Fever Welt at injection site Rash Diarrhea Fatigue Prolonged Cry
Seizures Developmental Regression Other ____________________
Does your child receive annual flu shots? No Yes (informed decision) Yes (recommended by MD)
Has your child been exposed to antibiotics? No Yes
If yes, how many doses in past 6 months? ________Reason____________________
Were probiotics used at the same time as antibiotics? No Yes
Has your child been exposed to medications, including OTC: No Yes
If yes, which ones? ____________________
If yes, how many doses in past 6 months? ________ Reason____________________
How many glasses of water/day does your child have? . . . . 0 1-3 4-6 7-9 10+
How many glasses of cow's milk, juice and soda/day does your child have: . . 0 1-3 4-6 7-9 10+
Does your child eat gluten? . . . . No Yes Trying to eliminate from diet
Does your child eat dairy? . . . . No Yes Trying to eliminate from diet
Does your child eat refined sugars (white sugar), white bread and pasta? . . No Yes Trying to eliminate from diet
Does your child eat boxed/frozen foods? . . . . No Yes Trying to eliminate from diet
Do you choose organic foods? No Yes If yes, which: Veggies Fruits Meats Grains All
Does your child eat any artificial sweeteners like Splenda, Aspartame, AminoSweet, Diet Soda? No Yes
Does your child follow any other dietary restrictions? No Yes ____________________
Any food/drink allergies, sensitivities, intolerances? No Yes ____________________
Is your child exposed to second hand smoke? No Yes ____________________
Does your child take a probiotic daily? No Yes:______ CFU's/day
Does your child take vitamin D3 daily? No Yes: ______ IU's/day
Does your child take Omega 3 Fish Oils daily? No Yes: ______mg/day Capsule Liquid
Other supplements or homeopathics? ____________________

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 clinic? ____________________

Our goals are to provide a detailed assessment of your child's current health 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, examination and x-rays if warranted. Any findings will be communicated before consenting to commencement of care, if appropriate.

____________________ ____________________
Consenting Adult's Signature Date

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