ABOUT YOUR CHILD

Today's Date _____

Name _____ **Age** _____ **Date of Birth** _____

Gender ❑ **M** ❑ **F** **Height** _____ **Weight** _____

Home Address _____**City** _____ **State** _____ **Zip** _____

Names and Ages of Siblings_____

Parent A	Parent B
Name _____	**Name** _____
Home phone (_____) _____	**Home phone** (_____) _____
Cell phone (_____) _____	**Cell phone** (_____) _____
Employer _____	**Employer** _____
E-mail _____	**E-mail** _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Well Spine KC can address for your child? _____

_____

Are they related to: ❑ **Sports** ❑ **Auto** ❑ **Fall** ❑ **Chronic** ❑ **Home Injury** ❑**Other** _____

Please describe how these concerns are affecting your child's quality of life. ____ _____

_____

Check all that apply

- ❑ **School**
- ❑ **Playing**
- ❑ **Communication**
- ❑ **Exercise/Sports**
- ❑ **Sleep**
- ❑ **Eating**
- ❑ **Walking**
- ❑ **Attention/Focus**
- ❑ **Daily Routine**

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply

- ❑ **Symptomatic relief of pain or discomfort**
- ❑ **Correction of the cause of the problem as well as relief of symptoms**
- ❑ **Prevention of future problems**
- ❑ **Healthier spine and nerve system**
- ❑ **Optimal health on all levels**
- ❑ **OTHER**_____

The primary system in the body, which coordinates health, is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses your child has been subjected to, how they may relate to his/her present spinal, nerve and health status and whether they may have caused Vertebral Subluxations to occur.

PREGNANCY & BIRTH

During pregnancy, did the mother:

❑ Use any form of fertility treatment? Y N What treatment: _____
❑ Experience any significant illnesses, difficulties, or trauma? _____
❑ Take any drugs/medications? _____
❑ Smoke or consume alcohol or caffeine _____
❑ Home birth ❑ Hospital birth ❑ Vaginal ❑ Water birth ❑ Caesarean

Was the delivery premature? ❑ No ❑ Yes Weeks _____Weight _____
Approximately how long did labor last? _____ hours
Was labor artificially induced? ❑ No ❑ Yes _____
Was it determined that the child was breech or otherwise malpositioned? ❑ No ❑ Yes _____

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered during labor and/or birth.

❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications _____
❑ Pitocin ❑ Episiotomy ❑ Manual traction of the neck _____

Please check all that apply to the baby's status immediately after birth:

❑ Jaundice ❑ Respiratory problems ❑Broken bones _____
❑ Feeding problem ❑ Displaced joints ❑ Other conditions _____

APGAR Score (if known) _____
Was the baby breastfed? ❑ No ❑ Yes For how long? _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

❑ Academic pressure ❑ Loss of a loved one ❑ Bullying ❑ Relocation
❑ Lifestyle change ❑ Parents' divorce ❑ Loss of a pet ❑ New sibling

Does your child have difficulty interacting with schoolmates or friends? ❑ Yes ❑ No
Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior?
❑ Yes ❑ No If so, please explain _____

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ❑ No ❑ Yes.
If yes, please check all vaccinations the child has received and at what age they were administered:

❑ DPT_____ ❑ MMR _____ ❑ Polio _____❑ Chicken Pox _____
❑ Hepatitis _____ ❑ Flu _____ ❑ Other _____
Please describe any reactions to vaccine(s)_____

Please check all that apply and give any necessary details:
❑ Child exposed to second hand smoke.
❑ Has taken antibiotics. Explain _____
❑ Currently taking medication. Explain _____
❑ Currently taking supplements. Explain _____
❑ Has allergies. Explain _____
What treatments have you used? _____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Is the reason you are seeking care related to:❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑Other
Please check all that apply to your child and give any necessary details:

❑ Uncoordinated/Accident prone _____
❑ Has been hospitalized _____Had Surgery_____
❑ Had a severe trauma _____
❑ Been in an automobile accident _____
❑ Has fractured a bone or dislocated a joint _____
❑ Has had a chronic illness _____
What physical activities or sports does your child participate in? _____

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ❑ Y ❑ N Name of D.C. _____

Date of last visit _____Why was care stopped? _____

Have you consulted or do you regularly consult any of the following providers for your child?

Check all that apply ❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath
❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Other

Reason _____

Is there anything else you would like to discuss with us about your child?_____

Thank you for choosing Well Spine KC!
We look forward to helping you.