Middleton Chiropractic

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Child's Name: ______________________ Date: ____________
Parents'/Guardians' Names: ______________________
Home Address: ______________________
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: ______________________
How did you hear about us? ______________________
Height (of child): ________ Weight: ________ Birth Date: ____________ Age: _____ Sex: _____
Siblings and ages: ______________________
Previous Chiropractic Care? ☐ Yes ☐ No

Emergency Contact
Name: ______________________ Relationship to child: ______________________
Phone number: ______________________ Alternative 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, OT, Massage Therapist, etc)
Name: ______________________ Professional Designation: ______________________
Clinic Name: ______________________ Date and reason of last visit: ______________________
Name: ______________________ Professional Designation: ______________________
Clinic Name: ______________________ 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.

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 *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	
☐	☐	Asthma
☐	☐	Respiratory Tract Infections
☐	☐	Sinus Problems
☐	☐	Ear Infections
☐	☐	Tonsillitis
☐	☐	Strep Throat
☐	☐	Frequent Colds / Croup
☐	☐	Recurrent Fevers
☐	☐	Eczema
☐	☐	Rashes
☐	☐	Allergies
☐	☐	Food Sensitivities
☐	☐	Digestive Problems

CURRENT	PREVIOUS	
☐	☐	Frequent Diarrhea
☐	☐	Constipation
☐	☐	Flatulence
☐	☐	Headaches/Migraines
☐	☐	Neck Pain
☐	☐	Torticollis / Head Tilt
☐	☐	Trouble Feeding on One Side
☐	☐	Back Pain
☐	☐	Growing Pains
☐	☐	Scoliosis
☐	☐	Red, Swollen, Painful Joint
☐	☐	Colic
☐	☐	Frequent Crying Spells

CURRENT	PREVIOUS	
☐	☐	Failure to Thrive / Slow Weight Gain
☐	☐	Slow or Absent Reflexes
☐	☐	Asymmetrical Crawling or Gait
☐	☐	Weight Challenges
☐	☐	Bed Wetting
☐	☐	Sleep Problems
☐	☐	Night Terrors
☐	☐	Tip Toe Walking
☐	☐	Sensory Processing Issues
☐	☐	Seizures
☐	☐	Tremors / Shaking
☐	☐	ADD / ADHD
☐	☐	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 or 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 received any treatment at this time? ☐ 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: ______________

Prenatal Profile

☐ Adopted ☐ Prenatal history unknown ☐ Birth history unknown

Complications during pregnancy: ☐ No ☐ Yes (brief description): ______________________________

Ultrasounds during pregnancy: ☐ No ☐ Yes (brief description): ______________________________

Medications during pregnancy: ☐ No ☐ Yes (brief description): ______________________________

If so which ones and how often? (include OTC):

Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy:

☐ No ☐ Yes (brief description): ______________________________

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 anytime during your 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

Post Natal & Infant History

How many weeks gestation was the baby at birth? ____________ Weight: _________ Length: _________

If known, APGAR scores at: 1 minute: ________/10 5 minutes: ________/10

Was the baby ever administered 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 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)? ☐ 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 your child spend a lot of time in any baby devices (bouncy 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? ☐ 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 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

Does your child show excessive or uneven shoe wearing out? ☐ No ☐ Yes

Does your child wear custom orthotics?

☐ No ☐ Yes, For what purpose? ____

Chemical Stressors

Have you chosen to vaccinate your child? ☐ No ☐ Yes, on a delayed schedule ☐ Yes, on schedule

Reason for vaccination: ☐ Personal research ☐ Didn't know I had a choice ☐ It was recommended

Reaction(s) to vaccination: ☐ None ☐ Fever ☐ Diarrhea ☐ Rash ☐ Welt at injection site

☐ Fatigue ☐ Seizures ☐ Prolonged Cry ☐ Developmental Regression

☐ Other: ____

Does your child receive annual flu shots? ☐ No ☐ Yes (personal research) ☐ Yes (MD recommended)

Has your child been exposed to antibiotics? ☐ No ☐ Yes

If yes, how many doses in past 6 months? _____ Reason: ____________________

Has your child been exposed to medications, including OTC?

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? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

Does your child eat gluten? ☐ No ☐ Yes ☐ Trying to eliminate

Does your child eat dairy? ☐ No ☐ Yes ☐ Trying to eliminate

Any food/drink allergies or sensitivities? ☐ 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 a vitamin D3 daily? ☐ No ☐ Yes __________ IU's/day

Does your child take Omega 3 Fish Oils daily? ☐ No ☐ Yes __________ mg/day

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, and physical examination. Any findings will be communicated before consenting to commencement of treatment, if appropriate.

____________________ ____________________

Consenting Adult's Signature Date