CONSCIOUS SOL
healing & wellness

CONFIDENTIAL CHIROPRACTIC NEW PATIENT HISTORY:
CHILD INTAKE FORM

Todays Date: _____

Child's Legal Name: _____ Nick name: _____

Address: _____City:_____State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Age: _____ Grade: _____ School: _____

Birth Date: _____ Height: _____ Weight: _____lbs ____oz.

Gender: *Female* *Male* Blood Type if known: _____

Mother's Name: _____Mother's Occupation: _____

Mother's Phone: _____ Mother's Email: _____

Father's Name: _____ Father's Occupation: _____

Father's Phone: _____Father's Email: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Phone: _____ Best form of contact: Email Text Call

May we add you to our newsletter for regular office updates? Yes No

Most patients are referred to our office from a caring family member or friend, what made you decide to contact us and How did you hear about us? _____

<u>Chiropractic Philosophy, Purpose, Mission & Vision:</u>

Our philosophy is that the nervous system controls and coordinates every organ and cell in the body. Our purpose is to educate and lead patients towards better health through the natural healing process. Our mission is to increase awareness that spinal care and preventative treatments are vital. Our vision is to see chiropractic care as the first choice in a patient's quest for the best health and wellness by correcting interferences (physical, emotional, chemical) allowing the being to express its inborn innate potential!

" It is easier to build strong children than to repair broken adults"

What is the reason for your child's visit today?

How can we help your child?

Your child is here for (circle): WELLNESS SYMPTOM DISEASE / CONDITION

If condition, please explain: _____

The purpose of this appointment is related to: (please check)

__ check-up __auto accident __sports __fall __condition __home injury __other:_____

Current Complaints or Symptoms: Please answer with detailed information in section below

Date of injury (if known) _____ Date symptoms first appeared: _____

Has your child ever had this same condition? if so, When: _____

Has this condition (circle): Gotten Worse Stayed the Same Come and Gone

Does this issue interfere with (circle): Sleep Daily Routine Other Activities None

Please explain:

_____
_____
_____

Has your child ever been under chiropractic care for this specific concern? YES NO

(please describe in detail including frequency, severity, duration and if it keeps them up at night:)

_____
_____

Has your child been treated for this symptom (s) on an emergency basis? YES NO

Please describe:

_____
_____

Have you seen other doctors / chiropractors / alternative therapies, etc for this? YES NO

Explain / type of treatment / results:

_____
_____
_____

Were you happy with the other treatments? YES NO If No, why?

_____
_____

Pregnancy History (if known fill out)**:**

Where there any complications during pregnancy? (circle all that apply)

Back Pain/Other Pain Gestational Diabetes Pre/Eclampsia Strep B

Nausea/Vomiting Pre-Term Fatigue Swelling Bed Ridden

OTHER (please describe):

_____

_____

Where there any ultrasounds or other tests performed during pregnancy? YES NO
Explain:

_____

_____

Where any illnesses present at all while pregnant? YES NO What did you do? Explain:

_____

_____

Previous Chiropractic Care:

Where you/mother under chiropractic care during/prior/post pregnancy? YES NO

When was your/mother's last adjustment? _____

Research shows that spinal problems often being at birth. How old was your child when they received their first chiropractic nervous system check? _____ or Never been checked before

Birth History:

Please circle: Adopted Prenatal history unknown Birth history unknown

Location of Birth: Hospital Birthing Center Home Birth Other: _____

Birth Attendants: Doula Midwife GP NP On your own with husband/friend/lover

Any other details you would like to share that will better assist me to understand you more:

_____

_____

_____

_____

Describe the delivery (if known)**:**

Difficult, long and/or doctor-assisted or chemical induced births can cause spinal irritations and also cause misalignments. Was your child born by any of these?

___ Labor was chemically induced ___Labor was doctor assisted ___ Epidural given

___Cesarean (C-Section delivery) ___Doctor pulled or twisted baby ___Forceps assisted

___Breech Delivery ___Premature delivery ___Suction/Vacuum assisted

Was the birth natural? (Non-Induced, Non-Scheduled, Vaginal) Please explain:
_____
_____

Were you able to breast feed right away? Any latching issues? YES NO Please explain:
_____
_____

Describe any ***complications*** during labor / delivery (please circle):

Antibiotics Congenital Anomalies Respiratory Distress Jaundice Meconium
Extended Hospitalization Failure to Thrive or OTHER: _____

How long was labor (first contraction until birth)? _____

How long was the second phase of labor/delivery (how long did you push for)? _____

Growth and Development: (under 5 years old)

Infant Feeding: Breast Bottle Formula (type): _____ How long? _____

Number of hours of sleep per night: _____ Quality of Sleep: _____

At what age did the child:

Respond to sounds: _____ Hold Head up: _____ Crawl: _____

Stand up: _____ Sit unsupported: _____ Walk unsupported: _____

Posture:

Poor posture leads to poor health and often indicates a spinal problem. How would you rate your child's posture? Poor Good Excellent Explain: _____

Have you ever been told your child has a spinal curvature, spinal arthritis or an inherited spinal problem?

Yes No Explain: _____

Childhood Diseases, Illnesses & Vaccinations:

Have you chosen to vaccinate your child? (circle) NO YES As Scheduled or Delayed Schedule

Has your child had any of these illnesses or vaccinations? (please circle ALL that apply):

Chicken Pox Measles Rubeola Mumps Rubella Pertussis / Whooping Cough OTHER

If NO vaccinations, but yes they have already had one or some of these illnesses? Explain:

_____

FLU's and Colds:

How often does your child get sick? _____

Is your child on any medications, antibiotics or chemical treatments currently? YES NO

Has your child been exposed to antibiotics? Yes No Explain: _____

Were probiotics used at the time as the antibiotics Yes No Other: _____

Has your child been exposed to medications, including OTC's? YES NO Reason: _____

How many dosages in the past 6 months? _____ Reason: _____

Does your child receive annual flu shots NO or YES (Informed Decision) YES (recommended by MD)

Wellness Profile: **The human body is designed to be healthy. The primary system in the body which coordinates health and functions 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 results may be misalignment to the final column and damage to the nervous system in a condition called vertebral subluxation. Please answer the following 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:**

Has your child had any of these? (place a "P" for Previous) or (place a "C" if Current) or circle **NONE** here:

Acid Reflux
ADD / ADHD
Allergies
Anemia
Arm Problems
Asymmetrical Crawling/Gait
Asthma
Autism
Back Aches
Back Pain
Bed Wetting
Behavioral Problems
Broken Bones
Cancer
Chronic Ear Aches/Infection
Colds/ Flus
Colic
Constipation (over 3 days)
Convulsions/ Seizures
Delayed Speech
Diarrhea
Diabetes
Digestive Issues
Dizziness
Eczema
Fainting
Failure to Thrive
Feeding on one side
Food Sensitivities
Frequent Crying Spells
Growing Pains
Headaches
Heart Issues
Infections
Juvenile Rheumatoid Arthritis
Joint Problems (red, swollen, painful)
Knee/Leg Problems
Neck Issues/Pain/Torticolis (head tilt)
Neuritis
Night Tremors
Orthopedic Problems
Poor Appetite
Rashes
Recurrent Fevers
Regression of Milestones
Ruptures / Hernias
Scoliosis
Seizures
Sinus Trouble
Sleep Problems
Slow Weight Gain
Spectrum Disorder
Strep Throat
Tip Toe Walking
Tonsillitis
Tremors/Shaking
Walking Problems
Weight Challenges

OTHER conditions or items not listed above: (please describe):

_____

_____

_____

Allergies, Medications, Surgeries: (please list and explain)

Allergies: Date / How long? Why? Meds:

_____
_____
_____
_____

Medications (current and past)**:**

_____
_____
_____
_____

Surgeries (current in last month and past)**:**

_____
_____
_____
_____

Other/Family Information:

Number of past pregnancies: _____

Are you currently pregnant? YES NO Due date: _____

Health concerns regarding this pregnancy? _____

How many children do you have? _____Children's ages (all): _____

Children's health challenges/concerns? _____

Do your children ever miss school for any physical reason or illness? Yes No

Do you worry about your children's health? Yes No

Do you miss work or sleep often due to your children's illnesses? Yes No

Do you have any health problems that affect your family? Yes No List:

_____
_____
_____

FREE OFFER: Would you and the rest of your family like to get your nervous system checked with FREE scans ($55 value) to see if you need chiropractic? YES NO (this is a one time free offer to educate your entire family and to find out if there are any underlying nervous system/spinal issues before symptoms even appear.)

Family Health History (please fill out below):

FAMILY MEMBER (list parent, child, etc. with name, age, deceased or alive)	**Present/past health conditions (List)** Ex: heart dx, cancer, diabetes, high BP, arthritis, dementia, etc…

Chemical Stressors: (if applicable to age of your child)

How many glasses of water/day does your child have? 0 1-3 4-6 7 -9 10+ Other: _____

How many glasses of cow's milk, juice and soda/day does your child have? _____

Does your child eat gluten? Yes No Trying to eliminate from diet

Does your child eat or drink dairy? Yes No Trying to eliminate from diet

Does your child eat refined sugars (white), white breads and pastas? Yes No Trying to eliminate from diet

Does your child eat boxed/frozen foods? Yes No Trying to eliminate from diet

Do you choose organic foods Yes No If Yes, which ones? Veggies Fruits Meats Grains ALL

Does your child have any artificial sweeteners? (Splenda, Aspartame, AminoSweet, Diet Sodas) Yes No

Does your child follow any other dietary restrictions? Yes No

Any food/drink allergies, sensitivities, intolerances? Yes No

Is your child exposed to second hand smoke at home, work or school? Yes No

Any environmental toxins your child is being exposed to daily? _____

Supplements (Vitamins, Herbs and Homeopathics**):** (list all current)

Supplement: Dosage: Reason taking and duration:

_____

_____

_____

_____

Is there anything else that I need to know to best serve your child? Please List:

_____

_____

_____

Physical/Emotional/Intellectual:

Is your child currently under a lot of pressure physically? Yes No _____

Any sports or prolonged postures for any reason? Yes No _____

Do you feel you child is developmentally appropriate for their age? Yes No

Intellectually Yes No _____
Emotionally: Yes No _____
Physically: Yes No _____

Any known learning disabilities? Yes No _____

Is your child currently under any type of counseling or psychiatric care: Yes No
Explain: _____
_____

Health Goals/ Management:

What is your primary goal and motivation to seek/receive care for your child in this office?
_____

If the doctor feels that your child will benefit from chiropractic care are you willing to follow the personalized recommendations? Yes No Other: _____

Intention for Care:

What is your intent for chiropractic care? Please circle **ALL** type (s) of care desired so that we may best understand the care you wish to participate in:

1- Pain Relief (for the relief of current issues/symptoms only)
2- Wellness & Health Supportive Programs (non-symptom based)
3- Nutrition & Supplementation Recommendations
4- I prefer Dr. Jodi to select the type of care she feels is best for my child

Patient's Signature _____ Date: _____

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Minors and Children (under 18 years old):

Authorization for treatment and care of a minor (if applicable):
The statements made on this form are accurate to the best of my knowledge. I hereby authorize this doctor to administer care as they so deem necessary to my son/daughter/ward.

Name of Minor (please print) _____
Parent/Guardian Signature _____ Date:_____
Witness_____ Date:_____