Pediatric Comprehensive Health Profile History

Welcome! As part of your first visit we will be gathering a thorough health history in order to best serve you. Please do your best to fill this out to the best of your ability, even if you do not feel it is relevant to why you're here. It is my job to understand all past and current stressors that have or currently are affecting you physically, chemically, mentally, emotionally and spiritually. Please know that I value your time and my goal is to provide you with the best possible care. Thank you for choosing Embodied Chiropractic!

Child's Name ____________________________________ DOB __________ Age ______ Sex ________
Parent/Guardian's Name ____
Address _____________________________________ City________________ State_____ Zip Code ________
Home Phone ________________________ Email ____________________________
Current Weight _______ Height _______ SS#________________________
Siblings' Names and Ages ____
Who referred you to our office? ____

Has your child ever been adjusted? Y N Doctor/Office Name:__________________________________
When? ________________________________ Duration of care: _____________________________________
Reason for visit: ________________________________ Result: _____________________________________
Technique used: ________________________________ Last Adjustment: _____________________________
Name of Pediatrician: ____
Date of Last Visit: _____/______/______ Reason: ____
Are you Satisfied with the Care Your Child Received There? Y N

Current Concerns

Reason for visit? ____
Other Dr's seen for this condition: ___________________________ Prior Treatments: _________________
Other Health Problems: ____
Please answer the following questions about the chief concern. (___________________)
When did this situation or concern first begin? ____
What activities aggravate their condition/pain? ____
____
What activities alleviate their condition/pain? ____
____
Is the condition worse during certain times of the day? Y N If yes, when? _________________________

Does it affect their ___school /___ exercise or play /___attitude, mood
___ sleep /___day-to-day activities
If your child can describe what's occurring, please answer the following:
Do they have: ___pain ___numbness ___tingling ___aches?
Is the pain: ___sharp ___dull ___throbbing ___constant ___intermittent?
Do they feel: ___swelling ___cramping ___stiffness ___burning?

On a scale of 1-10 (1 least, 10 most), please circle the severity of their symptoms (ask them):
1 2 3 4 5 6 7 8 9 10
Are there any other health concerns that are important to you?
____

Throughout life, stresses and traumatic events can damage the spine and nervous system. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature. Understanding all of these stresses that have acted upon your child's spine and nervous system assists Dr. Brenna in serving you and your family. Please answer the following questions as accurately as possible.

Prenatal & Birth History

Complications During Pregnancy? ______N _______Y, List: _______________________________________

Ultrasounds During Pregnancy? ______N ______Y, Number: _________

Medications During Pregnancy/Delivery: ______N _______Y, List: _________________________________

Cigarette/Alcohol Use During Pregnancy: ______N ______Y

Third Trimester Presentation: _____ Vertex _____ Breech _____Transverse _______Face/Brow
Type of Birth: _____Vaginal _____ Forceps _____ Suction or Vacuum _____ Cesarean (ER or Planned)
Interventions: _____ Pitocin _____ Epidural _____ Ruptured Membranes _____ Episiotomy
Delivery Location: ________________________________ OB/Midwife: ______________________________
Complications During Delivery: ______N ______Y, List: _______________________________________
Genetic Disorders or Disabilities: ______N _______Y, List: ______________________________________
Birth Weight ________ Birth Length _____ APGAR score________ , __________
Breast Fed: Yes No How Long? __________ Formula Fed: _____Dairy _____ Soy __________
Introduced Solids at: __________ Months, Cow's Milk at: __________ Months
Allergies: Foods_____________________________ Medicines ___________________ Other _____________
Food Sensitivities ____
Physical, emotional, or sexual abuse? Yes No Nightmares or Night Terrors? Yes No

Developmental History:

During the following times your child's spine is most vulnerable tostress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

______ Respond to Sound
______ Respond to Visual Stimuli
______ Hold Head Up
______ Sit Up
______ Cross Crawl
______ Stand Alone
______ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., bed, changing table, down stairs, etc.) Was this the case with your child? N Y

Is/has your child been involved in any high impact or contact type sport (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ________ N _______ Y, List: _________________________________
____
Has your child ever been involved in a Car Accident? ________ N _______ Y, List: ______________________
Other Traumas not described above: ____

Females: Menarche (1st Menstrual cycle) Yes No Age:_____ Cramps/PMS? Yes No

Chemical History

Vaccination History: ___ None ___ Select ___ Delayed, Full Schedule ___ Regular, Full Schedule

Number of Doses of Antibiotics Your Child has Taken:
In past 6 months: ________ Lifetime: _______ List: ____
Current over-the-counter and prescription drugs (type and reason):
____
Current vitamins and supplements (type and reason):
____

Health History

Mark each they have had in the past or have now and the age of occurrence.

___ Ear Infections/Aches
___Poor Appetite
___ Colic
___ Chronic Colds
___ Seizures
___ADD/ADHD
___Hernia
___ Leg problems
___ Broken bones
___ Scarlet Fever
___ Rotavirus
___Diptheria
___Croup
___Sinus/Allergies
___Digestive problems
___ Concussion/Head injury
___ Fifth Disease/ Parovirus
___ Motor Integration Issues
___ Diabetes
___ Muscle pain
___ Poor posture
___ Surgery
___Chicken Pox
___ Mumps
___ Colds/Flu
___Asthma
___Recurring Fevers
___ Neck or Back pain
___ Sensory Integration Issues
___ Anemia
___ Growing/Back pains
___ Scoliosis
___ Sports Injury
___ Rubella
___ Rubeola
___ Pertussis/Whooping Cough
___ Headaches
___ Eczema/Skin Condition
___ Reflux/Gassy
___ Heart/Valve Issues
___ Learning Disabilities
___ Bed Wetting
___ Arm problems
___Walking trouble
___ Auto Accident
___ Measles
___ Respiratory Issues
___ Hand, foot, mouth
___Other/FamilyHistory:____
____

Child's Diet / Mom's Diet if Breastfeeding

	Daily/High	Weekly/Moderate	Monthly or less/Low	None
Dairy (milk, yogurt, cheese)	______	______	_____	_____
Meat	______	______	_____	_____
Vegetables	______	______	_____	_____
Fruit	______	______	_____	_____
Gluten (flour, wheat, pasta)	______	______	_____	_____
Soy	______	______	_____	_____
Sugar	______	______	_____	_____
Soda/Energy Drinks	______	______	_____	_____
Fast food	______	______	_____	_____
Water	______	______	_____	_____

*Adequate (high) water intake means urine runs clear to only slightly yellow.
Circle all that apply if mom is breastfeeding: caffeine, coffee, tea, alcohol, tobacco, medications of any type

I AM HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctor(s) to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office:

Parent Signature: ____ Date: _________________

Participant Consent Form

When a participant seeks chiropractic health care and we accept a participant for such care, it is essential for both to be working toward the same objectives. It is important that each participant understand both the objectives and the methods that will be used to attain said objectives. This will prevent any confusion or disappointment. You have the right, as a participant, to be informed about the condition of your health and the recommended care and management to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science, art and philosophy that concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health.

Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. Therefore, symptoms are NOT a valid measure of health.

Subluxation is the physical manifestation of an un-integrated life experience. When one or more of the 24 vertebrae of the spinal column are misaligned, the system as a whole is affected: structurally, chemically, and tonally. This results in interferences to nerve system function, leading to tightened muscles and taught ligaments, therefore leading to a decrease in the body's overall, healthy performance.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce subluxation. Our chiropractic method of correction is by specific adjustments of the spine and related structural components. Adjustments are usually done by hand but may be performed by handheld instruments or specialized tables.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.
I will call the office if I have any questions or if any problems arise before each scheduled follow-up visit. I have read and understand all of the above statements.

I, ________________________ being the parent or legal guardian of _______________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____________________________________ _____________

Signature ***Date***