Health From Within
Chiropractic • Nutrition • Fitness • Family

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Pediatric

Infants & Toddlers
Wellness Profile and
Application for Care

Practice Member Information _____ File _____

Child's Name: _____ Appointment Date: Month _____ Day _____ Year _____
Parent's/Guardian's 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: _____
May we send you text messages as a method of communication? (Your cell phone# will not be shared)
☐ Yes ☐ No If 'Yes' - Cell phone carrier company: _____
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: Month _____ Day _____ Year _____ 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

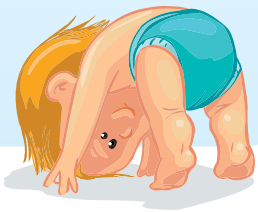
(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, Massage Therapist, etc)

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.



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	☐	☐	Constipation	☐	☐	Asymmetrical Crawling or Gait
☐	☐	Respiratory Tract Infections	☐	☐	Flatulence	☐	☐	Weight Challenges
☐	☐	Sinus Problems	☐	☐	Headaches/Migraines	☐	☐	Bed Wetting
☐	☐	Ear Infections	☐	☐	Neck Pain	☐	☐	Sleep Problems
☐	☐	Tonsillitis	☐	☐	Torticollis / Head Tilt	☐	☐	Night Terrors
☐	☐	Strep Throat	☐	☐	Trouble Feeding on One Side	☐	☐	Tip Toe Walking
☐	☐	Frequent Colds / Croup	☐	☐	Back Pain	☐	☐	Regression of Milestones
☐	☐	Recurrent Fevers	☐	☐	Growing Pains	☐	☐	Seizures
☐	☐	Eczema	☐	☐	Scoliosis	☐	☐	Tremors / Shaking
☐	☐	Rashes	☐	☐	Red, Swollen, Painful Joint	☐	☐	ADD / ADHD
☐	☐	Allergies	☐	☐	Colic	☐	☐	Autism / PDD / Aspergers
☐	☐	Food Sensitivites	☐	☐	Frequent Crying Spells	☐	☐	Behavior / Attention Challenges
☐	☐	Digestive Problems	☐	☐	Failure to Thrive / Slow Weight Gain	☐	☐	Sensory Issues
☐	☐	Frequent Diarrhea	☐	☐	Slow or Absent Reflexes	☐	☐	Vaccine Injury / Reactions

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:
Was there an apparent injury or event that brought this primary complaint on? ☐ No ☐ Yes
Does your child have any additional complaints besides the primary complaint?
Second: _____ Third: _____
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 / Vaccinations 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 _____

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 a fetal malposition or malpresentation? ☐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? _____
Were any of the following interventions used during delivery? ☐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 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? _____
Were any medications, shots, or vaccines given to the baby at birth? ☐ Yes ☐ No ☐ Unsure
If yes, which ones and why? _____

Child Health History *(Answer only those which are applicable)*

How many hours does your baby sleep between feedings?_____ Day _____Night
Does your child have a preferred sleeping position? ☐No ☐ Yes _____
Does your child have any feeding difficulties? ☐No ☐Yes _____
Is your child currently being breast fed? ☐Yes: exclusively breastfed ☐formula supplemented ☐No
If no, how long was the baby breast fed? _____ weeks/months
Does your child have a one-sided breast preference? ☐No ☐Yes If yes, Prefer Left or Right _____
Does your child frequently spit up after feeding? ☐No ☐Yes
Does your child cry often? ☐No ☐Yes If yes, approximately how many hours per day?_____
Does your child pass a lot of intestinal gas? ☐No ☐Yes
Does your child frequently arch his/her head and neck backwards? ☐No ☐Yes
Has your child shown any sensitivities to foods either in your diet or their own? ☐No ☐Yes _____
Is your child exposed to cow's milk/dairy? ☐No ☐Yes, formula ☐Yes, directly ☐Yes, I drink it and breastfeed.

Developmental History

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_____

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 are your top health goals for your child?

Short term (6-12 months): _____
Medium term (1-5 years): _____
Long term (5+ years): _____

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)

I 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 treatment, if appropriate. I hereby authorize payment to be made directly to HEALTH FROM WITHIN for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to HEALTH FROM WITHIN for any and all services I receive at this office.

_____ _____
Consenting Adult's Signature Date

_____ _____
Doctor's Signature Date Form Reviewed