Chiropractic Care Initial Consultation (CHILD)

Welcome
Our mission is to make Truro and Colchester County the healthiest communities on the planet! We are excited to start this process with YOU.
Subluxations or spinal misalignments are a condition of the spine that chiropractors are trained to detect. Research is now showing that dysfunction within the body can be the result of these subluxations. Often other symptoms are apparent for years before spinal pain is noticed. It is for this reason that we ask a wide variety of questions regarding your health.
Please complete the following the best you can.

Patient Information *Please Print*
Child's Name ______________________ Date *D/M/Y* ___/___/___
Parent(s) Name(s) ______________________
Sibling(s) Name(s) & Ages ______________________
Address ______________ Town ______________ Postal Code ________
Phone *Home* ______________ *Work* ______________ *Cell* ______________
Email *We use email for appointment reminders & primary method of contact* ______________
Age ______ D.O.B. *D/M/Y* ___/___/___ Gender *M/F* ______ Referred by ______________
Has your child ever received chiropractic care? Yes No
Name of Medical Doctor ______________________
Date of last MD visit *D/M/Y* ___/___/___ and reason for visit ______________

Authorization for Care of a Minor (under 16 years)

Parent(s) Name(s) ______________________ **Work Phone** ______________

I hereby authorize and consent to the chiropractic evaluation and care of my child.
As of this date, I have the legal right to select and authorize health care services for the minor child. Under the terms and conditions of my separation/divorce or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way I will immediately notify Well Within Chiropractic.

Parent/Guardian Signature ______________________ Date *D/M/Y* ___/___/___

Witness Signature ______________________

Present Health Concerns
Major ______________________
______________________ When did this problem begin? ______________
Minor ______________________
______________________ When did this problem begin? ______________

Be Fit. Eat Right. Think Well.

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Is this problem: ○ Occasional ○ Frequent ○ Constant ○ Intermittent
Does the problem radiate? ○ Yes ○ No If yes, where? ____________
What makes this worse? ____________
What makes this better? ____________
Is the problem worse during a certain part of the day? ○ Yes ○ No If yes, when? ____________
Doe this interfere with the child's: ○ Sleep ○ Eating ○ Daily Routine
Is this becoming worse? ____________
Other professionals seen for this condition? ____________
Results with that treatment? ____________

Other Symptoms

Often seemingly unrelated symptoms may manifest as other health concerns.
Please mark an X in the circles if your child has had any of the following:

- ○ Headaches
- ○ Dizziness
- ○ Fainting
- ○ Fatigue
- ○ Irritability
- ○ Depression
- ○ Loss of Balance
- ○ Loss of Concentration
- ○ Loss of Memory
- ○ Ears Buzzing
- ○ Poor Coordination
- ○ Vision Changes
- ○ Loss of Smell
- ○ Loss of Taste
- ○ Light Sensibility
- ○ Face Flushed
- ○ Cold Sweats
- ○ Bronchitis
- ○ Pneumonia
- ○ Frequent Colds
- ○ Sinus Congestion
- ○ Asthma
- ○ Urinary Problems
- ○ Constipation
- ○ Diarrhea
- ○ Weight Loss
- ○ Weight Gain
- ○ Dental Problems
- ○ Fevers
- ○ Heart Palpitations
- ○ Chest Pressure
- ○ Breast Pain
- ○ Numbness in Leg(s)
- ○ Numbness in Feet
- ○ Sore Throats
- ○ Ear Pain/Infections
- ○ Allergies
- ○ Heartburn
- ○ Bloating/Gas
- ○ Upper Back Pain
- ○ Neck Pain
- ○ Low Back Pain
- ○ Stiffness
- ○ Reduced Mobility
- ○ Concussion
- ○ Seizures
- ○ Numbness in Hand(s)
- ○ Weakness
- ○ Muscle Cramps
- ○ Sleeping Problems
- ○ Other ____________
- ○ Other ____________

History of Birth

What was the child's gestational age at birth? _____ weeks. Birth weight _____ lbs. _____ oz. Birth length _____ in.
Was your child's birth: ○ At home ○ In a birthing centre ○ In a hospital
Was the birth considered: ○ Medical ○ Midwife
What was the duration of the labour and birth? _____ hrs. Was labour: ○ Spontaneous ○ Induced
Was your child born: ○ Cephalic *Head first* ○ Breech *Feet first*
Where there any complications? ○ Yes ○ No If yes, please explain ____________

Any assistance used during birth: ○ Forceps ○ Vacuum Extraction ○ C-Section ○ Episiotomy
Were medications or epidurals given to the mother during birth? ○ Yes ○ No If yes, what was given?

APGAR score: At birth _____ /10 After 5 minutes _____ /10

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Growth and Development

Was the infant alert and responsive within 12 hours of delivery? ○ Yes ○ No If no, please explain ____

Has your child reached all the developmental milestones? ○ Yes ○ No
Do you consider the child's sleeping pattern normal? ○ Yes ○ No If no, please explain ____

Family Health History

Please note any health problems (i.e. cancer, hereditary conditions, diabetes, heart disease, etc) that are present in:

Mother's family ____
Father's family ____
Sibling(s) ____

Subluxations and poor health occur because of how our body adapts or doesn't adapt to physical, chemical and emotional stressors. Please help us see what stressors have been present for your child

Physical Stressors

Any traumas to the mother during pregnancy? *(i.e. falls, accidents, etc)* ○ Yes ○ No If yes, please explain ____

According to the National Safety Council, 50% of children fall head first from a high place during their first year of life. Any falls from couches, beds, change tables, etc? ○ Yes ○ No If yes, please explain ____

Any evidence of birth trauma to the infant?
○ Bruising ○ Odd shaped head ○ Stuck in birth canal ○ Cord around neck
○ Respiratory depression ○ Fast or excessively long birth

The vast majority of our patients have experienced dozens of falls or impacts *(auto, work, hobbies)* that could either begin or exacerbate subluxations. Help us discover a few of your child's:

Any traumas resulting in bruises, cuts, stitches or fractures? ○ Yes ○ No If yes, please explain ____

Any hospitalizations or surgeries? ○ Yes ○ No If yes, please explain ____

Which sports has the child been involved in? ○ Football ○ Soccer ○ Hockey
○ Equestrian ○ Basketball ○ Martial Arts ○ Gymnastics ○ Dance
○ Cheerleading ○ Other

Has the child ever experienced loss of consciousness or a concussion? ○ Yes ○ No If yes, please explain ____

Is a school backpack used? ○ Yes ○ No If yes, is it: ○ Heavy ○ Light

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Chemical Stressors

Was the child breast fed? ○ Yes ○ No If yes, how long? ____
Formula introduced at what age? ____ What formula? ____
Began solid foods at what age? ____ Type of foods? ____
Food/Juice intolerance? ○ Yes ○ No If yes, what type? ____
During pregnancy did the mother: Smoke? ○ Yes ○ No If yes, how much? ____
Drink? ○ Yes ○ No If yes, how much? ____
Any illnesses during the pregnancy? ○ Yes ○ No If yes, what illnesses? ____

Any supplements taken during the pregnancy? ○ Yes ○ No If yes, what supplements? ____

Any drugs taken during the pregnancy? ○ Yes ○ No If yes, what drugs? ____

Any procedures during the pregnancy? *(i.e. Amniocentesis, CVS,etc)* ○ Yes ○ No Please explain ____

Any pets at home? ○ Yes ○ No If yes, kind(s)? ____
Any smokers at home? ○ Yes ○ No
Vaccinations and age given?
Any negative reactions? ○ Yes ○ No If yes, what were they? ____
Any antibiotics given? ○ Yes ○ No Reason? ____

Psychosocial/Emotional Stressors

Any difficulties with lactation? ○ Yes ○ No If yes, what are they? ____
Any problems with bonding? ○ Yes ○ No If yes, what are they? ____
Any behavioural problems? ○ Yes ○ No If yes, what are they? ____
Any: ○ Night terrors ○ Sleep walking ○ Difficulty sleeping
Age of child when he/she began daycare? ____ Average number of hours of television per week? ____
Do you feel your child's social and emotional development is normal for their age? ○ Yes ○ No
If no, please explain? ____

Thank you for completing this form. If there are any other questions or concerns you may write them in the space below. ____

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