Pediatric

T3 Chiropractic

PEDIATRIC AND FAMILY WELLNESS CARE

PERSONAL INFORMATION

DATE: _____

Child's Name: _____

Parent's/Guardian's Names: _____

Home Address: _____

Parent's Phone Number: _____ Parent's Email: _____

May we add you to our email newsletter and calendar of events? (your email will not be shared) ☐ Yes ☐ No

Who should we thank for referring you to T3 Chiropractic? _____

Child's Hleght: _____ Child's Weight: _____ Date of Birth: _____ ☐ M ☐ F

Siblings and Ages: _____

What school setting is the child in? ☐ Public ☐ Private ☐ Home-School

What grade is the child in? _____

HEALTHCARE

Previous Chiropractic Care? ☐ Yes ☐ No If yes, who? _____

Date of last adjustment: _____

Frequency of Visits: Times per WEEK/MONTH (circle one) _____

How many WEEKS/MONTHS/YEARS total (circle one) _____

FAMILY HEALTHCARE PROVIDER

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and Reason of last visit: _____

May we communicate with your family healthcare provider regarding your child's care if necessary? ☐ Yes ☐ No

Additional Health Care Providers (Medical Specialist, Naturopathic Doctor, Homeopath, Physical Therapist, Etc.)

_____

WHY HAVE YOU DECIDED TO HAVE YOUR CHILD EVALUATED BY A CHIROPRACTOR?

- ☐ Child 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 my child's health and I'm looking for answers.
- ☐ Child has specific condition and I've learned that chiropractic may be able to help.
- ☐ I want to improve my child's immune function.

WELLNESS PROFILE

WHAT SIGNALS HAS YOUR CHILD'S BODY BEEN COMMUNICATING?

PREVIOUS	CURRENT		PREVIOUS	CURRENT		PREVIOUS	CURRENT		PREVIOUS	CURRENT	
☐	☐	Asthma	☐	☐	Allergies	☐	☐	Back Pain	☐	☐	Weight Challenges
☐	☐	Respiratory Tract Infections	☐	☐	Food Sensitivities	☐	☐	Growing Pains	☐	☐	Bed Wetting
☐	☐	Sinus Problems	☐	☐	Digestive Problems	☐	☐	Scoliosis	☐	☐	Sleep Problems
☐	☐	Ear Infections	☐	☐	Frequent Diarrhea	☐	☐	Red, Swollen, Painful Joint	☐	☐	Night Terrors
☐	☐	Tonsillitis	☐	☐	Constipation	☐	☐	Colic	☐	☐	Tip Tie Walking
☐	☐	Strep Throat	☐	☐	Flatulence	☐	☐	Frequent Crying Spells	☐	☐	Pregression of Milestones
☐	☐	Frequent Cold/Croup	☐	☐	Headaches/Migraines	☐	☐	Mood Swings	☐	☐	Seizures
☐	☐	Recurrent Fevers	☐	☐	Neck Pain	☐	☐	Failure To Thrive/Slow Weight Gain	☐	☐	Tremors/Shaking
☐	☐	Eczema	☐	☐	Torticollis/Head Tilt	☐	☐	Slow or Absent Reflexes	☐	☐	ADD/ADHD
☐	☐	Rashes	☐	☐	Trouble Feeding On One Side	☐	☐	Asymmetrical Crawling or Gait	☐	☐	Autism/SPD

DO YOU HAVE A SPECIFIC CONCERN THAT BRINGS YOU IN?

☐ Yes: _____

☐ No, I'm interested in having my child's nervous system assessed to achieve optimal health and functioning.

If yes, please anser the folling questions: _____

Does your child appear to be in pain or discomfort? ☐ yes ☐ no Was the onset sudden or gradual? _____

Have you seen other health professionals regarding this complaint? ☐ yes ☐ no If yes, whom? _____

What treatment did they use? _____

Has your child taken any medication for this compaint? ☐ yes ☐ no If yes, please list: _____

Has your child ever experienced this complaint before? ☐ yes ☐ no If yes, please list: _____

PRENATAL PROFILE

☐ Adopted ☐ Prenatal History Unknown ☐ Birth History Unknown

Complications during pregnancy? ☐ yes ☐ no If yes, explain: _____

Any exposures to ultrasounds during pregnancy? ☐ yes ☐ no If so, how many and what was the medical reason?

_____

Any drugs during pregnancy: ☐ yes ☐ no If so, which ones and how often? (Include over-the-counter and prescriptions) _____

Exposure to alcohol, cigarettes or second hand smoke during pregnancy: ☐ yes ☐ no

If yes, explain: _____

Any traumas during pregnancy? (falls/accidents) _____

Undgergo excessive stress? ☐ yes ☐ no Any complications? _____

BIRTH EXPERIENCE

Location of Birth: ☐ Home ☐ Birth Center ☐ Hospital ☐ Other:

Birth Attendants: ☐ Doula ☐ Midwife ☐ GP ☐ OB ☐ Other:

Were any of these utilized during labor/delivery? (check all that apply)

☐ Ruptured Membranes ☐ IV Antibiotics ☐ Epidural ☐ Pitocin

☐ Other Induction Methods and/or Pain Medications What was the medical reason?

Was your child at anytime during your pregnancy in an intra-uterine constraining position? ☐ yes ☐ no ☐ unsure

If yes, please descibe: ☐ Breech ☐ Transverse ☐ Face/Brow Presentation

Was the delivery ☐ Vaginal ☐ C-Section? If C-Section, was it scheduled or emergency? _____

If vaginal, was the baby presented: ☐ Head ☐ Face ☐ Breech

Were any of the following interventions used during delivery? _____

☐ Forceps ☐ Vacuum Extractions ☐ Episiotomy ☐ Dr. pull or twist baby

Were there any complications during delivery? ☐ yes ☐ no If yes, specify: _____

How long was the second stage (pushing phase) of the labor? _____

Was the baby born with any purple markings/bruising on their face or head? ☐ yes ☐ no

If yes, explain: _____

Any concerns about the misshapen head at birth? ☐ yes ☐ no If yes, explain: _____

Did any of the following occur at birth? ☐ Respiratory Depression ☐ Cord Around the Neck

POSTNATAL & INFANT HISTORY

How many weeks gestation was the baby at birth? _____W _____D

Birth Weight: _____ lbs. _____ oz. Birth Length: Inches

If known, APGAR scores at: 1min _____/10 _____5min/10

Was the baby ever administered to Neonatal Intensive Care? ☐ yes ☐ no If yes, how long any why? _____

_____

Was any medication given to the baby at birth? ☐ yes ☐ no If yes, what medication and why? _____

_____

Was your child: ☐ Exclusively Breastfed ☐ Formula Supplemented ☐ Exclusively Formula
If breastfed please answer the following:
How long was the baby breastfed? _____ weeks / months.
Does you child have any feeding difficulties? ☐ yes ☐ no
Any difficulties with lactation or latching? ☐ yes ☐ no
Does your child have a one-sided breast preference? ☐ yes ☐ no If yes, which side? ☐ Left ☐ Right
Did your child show any sensitivities to formula? ☐ Reflux ☐ Eczema ☐ Arching ☐ Back Frequently Spit Up
What age did you introduce solid foods to your child? _____
Did you introduce cereal or grains within your child's first year? ☐ yes ☐ no
Any problems with bonding? yes no If yes, explain: _____
Did/Do you practice attachment parenting methods? ☐ yes ☐ no (Check all that apply)
☐ Co-sleeping ☐ Kangaroo Care ☐ Feeding On Demand ☐ Extended breastfeeding ☐ Other: _____
Did your child spend excess time in any baby devices: (Check all the apply)
☐ Bouncer Seats ☐ Swing ☐ Bumbo ☐ Car Seats ☐ Other: _____
Was your child in daycare? ☐ yes ☐ no
If yes, started at what age? _____ How Long? _____ hrs/day _____ days/wk _____ mo/yrs
Does your child cry often? ☐ yes ☐ no If yes, approximately how many hours per day? _____
Does our child frequently arch his/her head and neck backwards? ☐ yes ☐ no

DEVELOPMENTAL HISTORY

Has your child experienced any of the following: (Check all the apply)
☐ Fallen from any high places ☐ Been involved in a motor vehicle accident or near miss
☐ Broken any bones ☐ Been hospitalized ☐ Had surgery
If any of the above have been checked please explain: _____

Does your child spend time using a tablet, computer or playing video games? ☐ yes ☐ no
If yes, how much time? _____
Does your child watch TV? ☐ yes ☐ no If yes, how much _____
Does your child exercise? ☐ yes ☐ no If yes, how much _____
Does your child play contact sports? ☐ yes ☐ no If yes, please list
Does your child sleep on their ☐ Back ☐ Belly ☐ Sides (both, right, left)
Does your child carry a back pack? ☐ yes ☐ no
Does it weigh less than 15% of their body weight? ☐ yes ☐ no
Do they wear their back pack on two shoulders? ☐ yes ☐ no ☐ sometimes
Does your child show excessive or uneven shoe wearing out? ☐ yes ☐ no
Does your child wear custom orthotics? ☐ yes ☐ no For what purposes? _____

CHEMICAL STRESSORS

Have you chosen to vaccinate your child? ☐ No ☐ Delayed/Selective Schedule ☐ Recommended Schedule
Reason for vaccination: ☐ Informed Decision ☐ Didn't Know I Had A Choice ☐ Recommended By MD
Reactions to vaccination: ☐ Fever ☐ Welt at Injection Site ☐ Rash ☐ Diarrhea ☐ Fatigue
☐ Prolonged Crying / Excessive Fussiness ☐ 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? ☐ yes ☐ no If yes, how many doses? _____
Were probiotics used at the same time as antibiotics? ☐ yes ☐ no

Has your child been exposed to medications, including OTC: ☐ yes ☐ no Explain:
If yes, how many doses in past 6 months? _____ Reason: _____
Does your child eat any of the following: (Check all that apply) ☐ Gluten ☐ Dairy ☐ Refined Sugar
☐ Boxed Foods ☐ Frozen Foods ☐ White Bread/Pasta/Rice ☐ Artificial Sweeteners
☐ Diet Soda ☐ Soda ☐ Juice
Do you choose organic foods? ☐ yes ☐ no
Does your child have any food allergies, sensitivities or dietary restrictions? ☐ yes ☐ no
If yes, explain: _____
Does your child have regular bowel movements? ☐ yes ☐ no If no, explain: _____
Is your child exposed to second hand smoke? ☐ yes ☐ no
Does your child take any of the following daily: ☐ Probiotic ☐ Vitamin D3 ☐ Omega-3 Fish Oil
Other supplements or homeopathics? _____
Are there other health concerns or anything else you'd like us to know about your child? _____

_____

Do you feel your child is developmentally appropriate for their age:
Intellectually: ☐ yes ☐ no If no, explain: _____
Emotionally: ☐ yes ☐ no If no, explain: _____
Physically: ☐ yes ☐ no If no, explain: _____
What health goal, if your child were to complete or accomplish it, would have the greatest impact in his or her life? _____
What is your level of commitment to your child's health? (circle one) 1 2 3 4 5 6 7 8 9 10
Explain: _____

_____

Our goals are to provide a detailed assessment of your child's current health status and provide you the resources for a highly engaged and healthy child whose body is functioning at it's absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference caused by subluxations. You've taken an important step for your child's future through a chiropractic evaluation.

CONSENT TO EVALUATE A MINOR

I _____ being the parent or legal guardian of _____ hereby grant permission for my child to receive a chiropractic evaluation including history, neuro-spinal analysis and examination.
Any findings will be communicated before consenting to commencement of care, if appropriate.
_____ DATE: _____

WITNESS: _____