



Child's Name: _____ Date: _____

Child's DOB: _____ Age: _____ Child's Height: _____ Weight: _____

Sex: ☐ Male ☐ Female Parent/Guardian Name: _____

Home Address/Zip: _____

Parent's Cell Number: _____ Alt. Phone Number: _____

Parent's E-mail: _____ Appointment Reminders: ☐ Text ☐ Email

How did you hear about us? _____

Emergency Contact Name: _____ Relationship to Child: _____

Phone number: _____ Alt. Phone number: _____

Family Doctor Name & Clinic: _____

Prof. Designation: _____ Date/Reason of Last Visit: _____

Other Healthcare Professionals: Medical Specialist, Naturopathic Doctor, Counselor, etc.

Name: _____ Prof. Designation: _____

Date/Reason for last visit: _____

Name: _____ Prof. Designation: _____

Date & reason for last visit: _____

Has your child received previous chiropractic care? ☐ Yes ☐ No

Why have you decided to have your child evaluated by us?

- ☐ 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

Do you have a specific concern that brings you in?

- ☐ No - We want a nervous system and general wellness assessment for optimal health
- ☐ Yes - If yes, please answer the following questions:

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? _____

Who, if anyone else, have you seen regarding this complaint? _____

What treatment did they use? _____

Has your child taken any medication for this complaint? ☐ No ☐ Yes, If so which: _____

Has your child ever experienced this complaint before? ☐ No ☐ Yes

Did they receive any treatment at that time? ☐ No ☐ Yes Had x-rays taken for it? ☐ No ☐ Yes

What is your primary goal for your child at our clinic? _____

Symptoms and Health History		
Current Previous	Current Previous	Current Previous
☐ Asthma	☐ Flatulence	☐ Failure to Thrive / Slow Weight Gain
☐ Respiratory Tract Infections	☐ Yeast Infections	☐ Slow/Absent Reflexes
☐ Sinus Problems	☐ Acid reflux	☐ Asymmetrical Crawl/Gait
☐ Ear Infections	☐ Ulcers	☐ Diabetes - Type: ☐ 1 ☐ 2
☐ Tonsillitis	☐ Appendicitis	☐ Weight Challenges
☐ Strep Throat	☐ Anemia	☐ Bed Wetting
☐ Thrush	☐ Bleeding Disorder	☐ Sleep Problems
☐ Frequent Colds / Croup	☐ Headaches/Migraines	☐ Night Terrors
☐ Recurrent Fevers	-How often: _____	☐ Tip Toe Walking
☐ Chicken Pox	☐ Neck Pain	☐ Regression Milestones
☐ Mononucleosis	☐ Torticollis / Head Tilt	☐ Seizures
☐ Eczema	☐ Trouble Feeding on One Side	☐ Tremors / Shaking
☐ Rashes	☐ Back Pain	☐ ADD / ADHD
☐ Allergies	☐ Growing Pains	☐ Autism / PDD
☐ Allergy shots	☐ Scoliosis	☐ Psychiatric care
☐ Digestive Problems	☐ Red, Swollen, Painful Joint	☐ Other: _____
☐ Frequent Diarrhea	☐ Colic	
☐ Constipation	☐ Frequent Crying Spells	

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 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? ☐ No ☐ Yes

Were your membranes ruptured by a medical professional? ☐ No ☐ Yes

Was your child at anytime during your pregnancy in an intra-uterine constraining position? ☐ No ☐ Unsure

☐ Yes - If yes, please describe: ☐ Breech ☐ Transverse ☐ Face / Brow presentation

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

☐ C-section - If a C-section: ☐ Planned ☐ Emergency

Interventions used during delivery, if any? ☐ 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? ____ Hrs

Length of second stage (pushing phase) of the labor? ____ Hrs

Any purple markings / bruising on baby's face or head at birth? ☐ No ☐ Yes

Any concerns about misshapen head at birth? ☐ No ☐ Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? ____ Wks ____ Days Birth weight ____ lbs ____ oz

Birth length: ____ inches If known, APGAR scores at: 1 minute ____ /10 5 minutes ____ /10

Any time spent in Neonatal Intensive Care? ☐ No ☐ Yes - If yes, for how long? _____ Why? _____

Was any medication given to the baby at birth? ☐ No ☐ Unsure ☐ Yes, the following medications and why: _____

Exclusively breastfed? ☐ No ☐ Yes, for ____ mos Breastfed + formula fed? ☐ No ☐ Yes, for ____ mos

Any sensitivities to formula (reflux, eczema, arching back, frequent spit up)? ☐ No ☐ Yes

Age solid foods introduced? ____ mos Was child introduced to cereal/grains in 1st year? ☐ No ☐ Yes

Did/Do you practice any attachment parenting methods: ☐ Kangaroo care ☐ Elimination communication

☐ Cosleeping ☐ Feeding on demand ☐ Extended breastfeeding ☐ Other: _____

Significant time spent in any baby devices such as, bouncer seats, swings, bumbos, car seats, etc.)?

☐ No ☐ Yes: _____

Physical Traumas

Has your child ever fallen from any high places? ☐ No ☐ Yes: _____

Has your child 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: _____

Lifestyle Factors

Child's frequency of tablet, computer or video games use: ☐ Never ☐ Rarely ☐ Daily ☐ Several hrs/day

Child's TV watching frequency: ☐ Never ☐ Rarely ☐ Daily ☐ Several hrs/day

Child's exercise frequency: ☐ Never ☐ Rarely ☐ Daily ☐ Several hrs/day

Does your child play contact sports? ☐ Never ☐ Rarely ☐ Daily ☐ Several hrs/day

Does your child sleep on their: ☐ Back ☐ Belly ☐ Sides (☐ both, ☐ right, ☐ left)

Does your child carry a backpack? ☐ No ☐ Yes Approximate weight of backpack: _____ lbs

Do they wear their backpack on 2 shoulders? ☐ No ☐ Yes ☐ Sometimes

Does your child show excessive or uneven shoe wearing out? ☐ No ☐ Yes

Does your child wear custom orthotics? ☐ No ☐ Yes, For what purpose? _____

Chemical Stressors

Has your child been vaccinated? ☐ No ☐ Yes, on a delayed or selective schedule ☐ Yes, on schedule

Reason for vaccination: ☐ Informed decision ☐ Unaware of choice to do so or not ☐ It was recommended

Reaction(s), if any, to vaccination: ☐ Fever ☐ Welp 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 taken antibiotics? ☐ No ☐ Yes - Doses in past 6 months: _____

Reason(s): _____ Were probiotics taken concurrently? ☐ No ☐ Yes

Any other medications taken, including OTC: ☐ No ☐ Yes: _____ For _____

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 ☐ Decreasing it in diet ☐ Not sure

Does your child eat dairy? ☐ No ☐ Yes ☐ Decreasing it in diet

Does your child eat refined sugars (white sugar), white bread and pasta? ☐ No ☐ Yes ☐ Decreasing in diet

Does your child eat boxed/frozen foods? ☐ No ☐ Yes ☐ Decreasing in diet ☐ Not sure

Does your child eat any artificial sweeteners like Splenda, Aspartame, Diet Soda? ☐ No ☐ Yes

Does your child follow any other dietary restrictions? ☐ No ☐ Yes: _____

Any food/drink allergies, sensitivities, intolerances? ☐ No ☐ Yes: _____

How much of your food is organic? ☐ None ☐ Some ☐ All

Is your child exposed to secondhand smoke? ☐ No ☐ Yes

Supplements/Other

Omega 3 Fish Oils? ☐ No ☐ Yes _____ mg/day ☐ Caps ☐ Liqui

Does your child take: Vitamin D3? ☐ No ☐ Yes, _____ IU's/day Probiotics? ☐ No ☐ Yes, _____ CFU's/day

Other supplements or homeopathics? _____

Do you feel your child is developmentally appropriate for their age:

Intellectually: ☐ Yes ☐ No

Emotionally: ☐ Yes ☐ No

Physically: ☐ Yes ☐ No