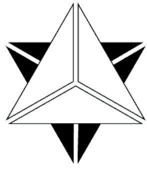

THE SOURCE
CHIROPRACTIC

Pediatric Patient Introduction (0-7 yrs)

Child's Name:___________________________ Date:__________________________________

Parent Name:___________________________Parent Name:____________________

Address:_______________________________City:_______________State:______Zip:___________

Home Phone:____________________ Parent Work Phone:___________________________

Birth Date:________/____/________ Age: _______ Sex: Male/Female

Current Weight:___________________________ Current Height:_________________

Pregnancy & Fertility History:

Any fertility issues? Yes No If yes, please explain: __________________________

Did mother smoke? Yes No If yes, how many per week? ___________________________

Did mother drink? Yes No If yes, how many per week? ___________________________

Did mother exercise? Yes No If yes, please explain: __________________________

Was mother ill? Yes No If yes, please explain: __________________________

Any ultrasounds? Yes No If yes, please explain: __________________________

Please explain any notable episodes of mental or physical stress during your pregnancy:

____

____

____

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

____

____

____

Labor & Delivery History

Child's birth weight: __________ lbs. oz. Child's birth height: __________ in.

Child's birth was: Vaginal Birth Scheduled C-section Emergency C-section

At how many week's was your child born? ____

Child's birth was: At home At a birthing center At a hospital Other: ___________

Obstetrician/Midwife's Name: ____

Please circle any applicable interventions or complications:

Breech Induction Pain meds Epidural Episiotomy Vacuum extraction

Medical Induction Forceps Pitocin Other:

Please describe any other concerns or notable remarks about your child's labor and/or delivery.

____

____

____

Growth & Development History:

Is/was your child breastfed? Yes No If yes, how long? ____________________________

Difficulty with breastfeeding? Yes No

Did they ever use formula? Yes No

Did/does your child ever suffer from colic, reflux, or constipation as an infant?

Yes No - If yes, please explain: ____

Did/does your child frequently arch their neck/back, feel stiff, or bang their head?

Yes No - If yes, please explain: ____

At what age did the child:

Respond to sound:_____ Follow an object:_____ Hold their head up:_____

Vocalize:_____ Teethe:_____ Sit alone:_____ Crawl:_____ Walk:_____

Begin cow's milk:_____ Begin solid foods:_____

Does your Child seem to be developing typically for their age? ___________________________

Please list any food intolerance or allergies, and when they began: ________________________

____

____

Please list your child's hospitalization and surgical history, including the year: _______________

____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year: ____

____

____

Have you chosen to vaccinate your child? No Yes

If yes, _____on an alternate schedule _____on schedule

If yes, please list any vaccination reactions: ___________________________________

____

Has your child received any antibiotics? Yes No

If yes, how many times and list reason:___________________________________

____

Night terrors or difficulty sleeping? Yes No

If yes, please explain: ____

____

Behavioral, social or emotional issues? Yes No

If yes, please explain: ____

____

How many hours per day does your child typically spend watching a TV, computer, tablet or phone? ____

How would you describe your child's diet?

_____Mostly whole, organic foods _____Pretty average _____High amount of processed foods

Health Concerns:

Please list any health concerns below:

____

____

____

When did the condition first begin? ____

How did the problem start? Suddenly Gradually Post-Injury

Has your child ever received care for this condition before? Yes No

If yes, please explain: ____

Is this condition: Getting worse Improving Intermittent Constant Unsure

What makes the problem better? ____

What makes the problem worse?____

Health Goals:

What are your top three health goals for your child?

1. ____
2. ____
3. ____

CIRCLE ANY AND ALL OF THESE PROBLEMS WHICH HAVE HAPPENED

DIZZINESS/ VERTIGO	ASTHMA	KIDNEY PROBLEMS	CHRONIC FATIGUE
HEADACHES/ MIGRAINES	TROUBLE EATING	BLADDER PROBLEMS	RASHES
ANTIBIOTICS	ALLERGIES	BED WETTING	TROUBLE SLEEPING
EAR INFECTIONS	ARM NUMBNESS	SCIATICA	ADD/ADHD
GRATING OF NECK	ARM PAIN	LEG NUMBESS	GERD
DIFFICULT BREAST FEEDING	NIGHT TERRORS	FEET NUMBENSS	ANXIETY
NECK PAIN/ STIFFNESS	SHOULDER PAIN	LOW BACK PAIN	NERVOUSNESS
TORTICOLLIS	HEART DISORDER	HIP PAIN	EPILEPSY
COLIC	MID BACK PAIN	LEG PAIN	VACCINE REACTION
CHRONIC SINUS	STOMACH DISORDER	KNEE PAIN	OTHER
THROAT ISSUES	LIVER DISEASE	TONGUE/LIP TIE	
SENSORY PROCESSING ISSUES	BOWEL PROBLEMS	AUTISM SPECTRUM DISORDER	

THE SOURCE
CHIROPRACTIC

If this health profile is for a minor/child, please fill out & sign

Written Consent For A Child/Minor

Name of Patient Who Is A Child/Minor:____

I authorize The Source Chiropractic doctors to perform a functional exam, render chiropractic care and perform chiropractic adjustments to my child/minor.

As of this date, I have legal right to select and authorize health care services for my child/minor. If my authority to select and authorize care is revoked or altered, I will immediately notify The Source Chiropractic.

_______________________________ _______________________________ ________________

Guardian Name Guardian Signature Date

____ _______________________________________

Guardian's Relationship to Child/Minor Witness Signature (Office Staff)