

Welcome to 50th & France Chiropractic & Wellness

Children's Case History

Today's date: _____

Name: _____ Birthdate: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Parents' Names: _____

Parent's Cell Phone: _____ Other Phone: _____

Appointment Text Reminders? Yes No

Siblings and ages: _____

Were you referred to our office? If so, by whom: _____

List current medications _____

List all allergies _____

What brings you in today? _____

Top Three Health Concerns:

The human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. The healthy function of every cell, every system, every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system. From the birth process until the present, events have occurred in your child's life which may have caused interference and damage to this delicate system. Physical, emotional and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the **Vertebral Subluxation Complex**. This form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of your child's nervous system and therefore impair your child's inborn health and well-being.

Vertebral Subluxation Assessment

1. Has your child been checked by a Doctor of Chiropractic? Yes No

Who? _____

Were x-rays taken? Yes No

Who is your regular pediatrician? _____

2. Experts around the world agree: the birth process as we know it may cause extensive neurological trauma, damage and even death to the infant.

Did you have ultrasound during this pregnancy? Yes No Frequency _____

Place of birth: Home Birthing Center Hospital

Provider: Midwife OB/Gyn Other _____

Type of Birth: Vaginal C-section

Was anesthesia used? Yes No Type: _____

Was labor induced? Yes No

If yes, why? _____

What position did you deliver: Squatting On back

Birth Trauma? Doctor assisted Twisting, pulling Vacuum Extraction Forceps

Newborn trauma (medical procedures and tests) _____

3. Did you breast-feed your child? Yes No How long? _____

Was your decision supported by your health care provider? _____

Repeated studies are now informing us breast-feeding develops strong and healthy immune, neurological, and digestive systems.

4. According to the National Safety Council, approximately 50% of infants have fallen onto their heads during their first years of life. Another study reveals 1/4 million children are injured in playgrounds annually.

Can you recall any such jolts, falls or traumas to your child? Yes No

Please describe: _____

Any fractures or dislocations? _____

5. Which sports does your child play? _____

6. Other than the 5 hours per day spent sitting in the classroom, does your child spend additional prolonged time sitting? _____ Is it in front of a computer or TV? _____

7. How would you rate your child's diet? _____

Does your child consume artificial sweeteners? Yes No

Fluoridated water? Yes No

8. Conditions your child has suffered from (select all that apply):

Colic Irregular Sleep Patterns Night Terrors Seizures Tantrums
Allergies Ear Infections Asthma Headaches Poor Digestion
Repeated Infections or Colds Bed Wetting Learning Disorders ADD/ADHD
Other _____

9. How often has your child been treated with drugs? _____

Were you informed of their adverse reactions? _____

If it was an antibiotic, was your child cultured for its use? _____

List surgeries _____

10. The child's immune system, like all other developing systems of the body is both intricate and delicate. It strives for a state of homeostasis and balance in the body. Long term, adverse effects from interfering with this process with artificial immunizations are just being uncovered.

Were you adequately informed of the risks of vaccinating your child? Yes No

Did your child experience any behavioral, emotional, or physical changes within 3 months after any shots?

Yes No Describe: _____

Was it reported by you or your doctor? _____

Authorization to Take and Publish Photographs

I authorize 50th & France Chiropractic & Wellness to take and publish photographs of my child for clinical records. Such photographs may be used in publications for the purpose of scientific and/or clinical research, chiropractic education, and the promotion of chiropractic health care when the doctor deems such publication will benefit these goals. I also understand I will not be identified by name without additional authorization. Entering/typing name in the signature field above constitutes signing the document, confirming the signer has read, understands, and agrees to the terms and conditions stated.

Signature

Date

Witness

Parent/Guardian Written Name