Breathe Chiropractic

# Childrens Intake Form
Todays Date:_____

Name: _____
Age: _____ Date of Birth: _____ Gender: ____ M ____ F
Home Address: _____
City: _____ State: _____ Zip: _____
Names & Ages of Siblings: _____

Parent 1 Name: _____ Parent 2 Name: _____

Home phone: (_____) _____ Home phone: (_____) _____

Cell phone: (_____) _____ Cell phone: (_____) _____

Employer: _____ Employer: _____

E-mail: _____ E-mail: _____

Whom may we thank for referring you to our office?_____

## REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Soloman Chiropractic can address for your child?

_____

Please indicate below how these concerns are affecting your child's quality of life. *(Circle all that apply)*

| | | |
|---|---|---|
| School | Exercise/Sports | Walking |
| Playing | Sleep | Attention/Focus |
| Communication | Eating | Daily Routine |

Other:_____

## HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ❑Y ❑ N
Name of D.C. _____
Reason_____
How long?_____Date of last visit _____
Why was care stopped_____

Other specialists, healthcare professionals or alternative therapists regularly consulted :

_____

The primary system in the body which coordinates health is the nerve system. The vertebrae, bones of the spinal column, surround and protect the delicate nerve system. Injury to the spine and nerve system is a condition called vertebral subluxation. Vertebral subluxation results in nerve malfunction due to vertebral/spinal misalignment. Vertebral subluxations can have physical, emotional, and chemical causes and effects.

The information below helps the chiropractor see the types of PHYSICAL, CHEMICAL & EMOTIONAL stresses your child has been subjected to; how they may relate to his/her present spinal, nerve and health status and whether they may have played a part in creating vertebral subluxations.

## PREGNANCY & BIRTH

The birth process can be traumatic to a baby's spine and cause interference to the nervous system

**During pregnancy did the mother:**

Experience any illnesses, difficulties, or trauma? ❑Y ❑ N List:_____

Take any drugs/medications? ❑Y ❑ N List:_____

Smoke or consume alcohol? ❑Y ❑ N List:_____

Have ultrasound(s) ? ❑Y ❑ N How many?

Was the delivery premature? ❑Y ❑ N Weeks: _____Weight: _____

Approximately how long did labor last? _____ hours

Was labor induced? ❑Y ❑ N

Was the child in a breech position (butt down) or otherwise mispositioned? ❑Y ❑ N

Please check where the child was born & if any of the following were administered during labor and birth.

❑ Home birth ❑ Hospital ❑ Vaginal ❑ Caesarean ☐ Water Birth
❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications
❑ Pitocin ☐ Episiotomy ☐ Manual traction of the neck

**Please check all that apply to the child's status immediately after birth:** APGAR Score _____

❑ Jaundice ❑ Respiratory problems ❑ Broken bones: _____
❑ Feeding problem ❑ Displaced joints ❑ Other conditions: _____

Was the baby breastfed? ❑Y ❑ N For how long? _____.

## PHYSICAL STRESS: INFANCY & CHILDHOOD

Please check all that apply to your child and give any necessary details:

❑ Developmental disorders or delays List_____
❑ Has been hospitalized Why?_____
❑ Had a severe trauma or concussion?
❑ Been in an automobile accident Were there injuries?_____
❑ Has fractured a bone or dislocated a joint. Which?_____
❑ Has/had a chronic illness. What? _____
❑ Has had surgery. Why? _____

What physical activities does your child participate in? _____

Does your child spend time using a tablet, computer or video games? ❑ Never ❑Occasionally ❑ Daily

How would you rate your child's sleep? ❑ Good ❑Poor How many hours daily? _____

## CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced. If yes, please check all vaccinations the child has received and at what age they were administered:

❑ DPT _____ ❑ Hepatitis _____ ❑ Chicken Pox _____
❑ Polio _____ ❑ MMR _____ ❑ Flu _____
Other _____

Please check all that apply and give any necessary details:

- ❑ Child exposed to second hand smoke.
- ❑ Has taken antibiotics. *Explain:* _____
- ❑ Currently taking medication. *Explain:* _____
- ❑ Currently taking supplements. *Explain:* _____
- ❑ Has allergies. *Explain:* _____

What treatments have you used? _____

Rate your child's diet on a scale of 1 – 10 with 1 being nothing but fast and processed foods and 10 being a diet consisting primarily of organic fruits and vegetables, whole grains and lean grass fed meats: _____

## EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below: *(check all that apply)*

| | | | |
|---|---|---|---|
| ❑ Academic pressure | ❑ Loss of a loved one | ❑ Bullying | ❑ Relocation |
| ❑ Lifestyle change | ❑ Parents' divorce | ❑ Loss of a pet | ❑ New sibling |

Does your child have difficulty interacting with schoolmates or friends? ❑Y ❑ N

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior?

❑Y ❑ N

## YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like my child to experience the following benefits from Chiropractic Care: *(Check all that apply)*

- ❒ Symptomatic relief of a problem
- ❒ Prevention of future problems
- ❒ Healthier spine and nerve system
- ❒ Optimal health on all levels
- ❒ Other _____

*Thank you for choosing Breathe Chiropractic*

*The information I have provided on this case history form is true and accurate to the best of my knowledge. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon. I give the doctors at BFC permission to render care to my child today.*

**Name:** (printed) _____ **Date:** _____

**Signature:** _____

**Signature of Parent** (for minor)**:** _____