Empowered Life, PC
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Pediatric
School Aged Children

Practice Member Information_____ File#_____

Child's Name: _____ Apt. Date: M ____ D ____ Y_____
Parent's/Guardian's Name: _____
Home Address: _____
City: _____ State:_____ Zip: _____
Home Phone: _____ May we leave a message? __ Yes __ No
Cell Phone: _____ May we leave a message? __ Yes __ No
Work Phone: _____ May we leave a message? __ Yes __ No
Parent's Email: _____
May we add you to our email newsletter and calendar of events? ___ Yes ___ No (Your email will not be shared)
How did you hear about us? _____
Height (of Child): _____ Weight (of Child): _____ Birth Date: M___ D___ Y_____ Age: ___ Sex: __M __F
Siblings and ages: _____ _____ _____ _____
Previous Chiropractic Care? __ Yes __ No

Emergency Contact

Name: _____ Relationship to Child: _____
Phone number: _____ Alternate phone number: _____

Family Doctor

Name: _____ Professional Designation: _____
Clinic Name: _____ Date and reason of last visit: _____
May we communicate with your family doctor regarding your child's care if necessary? __ Yes __ No

Other Health Care Professionals

(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, Massage Therapist, etc.)

Name: _____
Professional Designation: _____
Date and reason of last visit: _____

Name: _____
Professional Designation: _____
Date and reason of last visit: _____

Why have you decided to have your child evaluated by a Chiropractor?

__ 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 concern and I've learned that chiropractic may be able to help
__ I want to improve my child's immune function.

Wellness Profile

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called **vertebrae**. Many of the common health challenges that adults experience have their origins during the **developmental years**, some starting at birth. Layers of damage to the spine and **nervous system** occur as a result of various **traumas, toxins and emotional stress**. The result may be misalignment to the spinal column and damage to the nervous system in a condition called **Vertebral Subluxation**. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's **ability to heal**.

Who is bringing in the child?
__ Mother __ Father __ Grand-mother __ Grand-father __ Babysitter __ Legal Guardian

Do you have a specific concern that brings you in?
__ No, I'm interested in having my child's nervous system assessed to achieve optimal health and functioning.
__ Yes: _____

If yes, please answer the following questions:

What is the child's complaint?

__ No problems	__ Enuresis	__ Mid back pain	__ Right hand pain
__ Acid reflux	__ Epilepsy	__ Low back pain	__ Left hip pain
__ ADD	__ Febrile convulsions	__ Pelvic pain	__Right hip pain
__ ADHD	__ Fever	__ Left shoulder pain	__ Left leg pain
__ Asperger's	__ Foot flare	__ Right shoulder pain	__ Right leg pain
__ Autism	__ Headache	__ Left arm pain	__ Left knee pain
__ Cerebral palsy	__ Inability to thrive	__ Right arm pain	__ Right knee pain
__ Colic	__ Jaundice	__ Left elbow pain	__ Left calf pain
__ Congenital anomalies	__ Seizures	__ Right elbow pain	__ Right calf pain
__ Difficulty eating	__ Sleeping problems	__ Left forearm pain	__ Left ankle pain
__ Difficulty walking	__ Speech difficulties	__ Right forearm pain	__ Right ankle pain
__ Digestive problems	__ Torticollis	__ Left wrist pain	__ Left foot pain
__ Down's Syndrome	__ Neck pain	__ Right wrist pain	__ Right foot pain
__ Ear infections	__ Upper back pain	__ Left hand pain	

__ Other: _____

When did the complaint start?

__ For an unknown period of time	__ For the past two days	__ For the past month
__ Since the accident on _____	__ For the past three days	__ For the past several months
__ Since waking up	__ For the past several days	__ For the past year
__ For the last few hours	__ For the past week	__ For the past several years
__ All day	__ For the past few weeks	

When is the complaint worse?

__ In the morning	__ In the late afternoon	__ When going from seated to standing
__ During the day	__ In the evening	__ When going from lying to upright
__ In the mid day	__ All day	__ Other: _____
__ In the afternoon	__ While trying to sleep	_____

The complaint can be qualified as:

__ Sharp	__ Numb	__ Random	__ Discomfort
__ Dull	__ Shooting	__ Insidious	__ Tightness
__ Aching	__ Intense	__ Comes and goes	__ Throbbing
__ Buring	__ Continuous	__ Numbness	__ Varying with activity
__ Tingling	__ Intermittent	__ Pain	__ Increasing with movement
__ Mild nuisance	__ Mild to moderate but can live with it		__ Moderate, having trouble coping with it
__ Severe, ruining the quality of life		__ Other_____	

Have you seen other health professionals regarding this complaint?
__ No __ Yes: whom? _____
What treatment did you use? _____
Has your child taken any medication for this complaint? . . . . . __ No __ Yes _____
Has your child ever experienced this complaint before? . . . . . __ No __ Yes _____
Did they receive any treatment at the time? . . . . . __ No __ Yes _____
Has your child had x-rays in relation to the current complaint?. . . . . __ No __ Yes _____

Is there a history of any other health complaints?

__ No problems	__ Enuresis	__ Mid back pain	__ Right hand pain
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__ Other: _____

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 Center __ Other _____
Birth Attendants: __ Doula __ Midwife __ GP __ OB __ Other _____
Medications during labor/delivery? (including IV antibiotics) __ No __ Yes _____
Was Pitocin Used in induce/speed up labor: __ No __ Yes
Were your membranes ruptured by a medical professional? __ No __ Yes
Was our child at anytime during your pregnancy in an intra-uterine constraining position? __ No __ Yes __ Unsure
If yes, please describe: __ Breech __ Transverse __ Face / Brow presentation
How was your child delivered?
__ Unknown method __ Vaginal delivery at home __ Vaginal delivery with epidural __ vaginal delivery without epidural
__ C-section: __ planned __ emergency / if vaginal, was baby presented: __ Head __ Face __ Breech
How many hours was labor? _____ How long was pushing? _____
Were forceps used? __ No __ Yes
Was vacuum extraction used? __ No __ Yes __ May or may not have been used
Were there any complications during delivery? __ No __ Yes
If yes, please specify: _____
Was the child breastfed? __ No __ Yes Was the child vaccinated? __ No __ Yes __ May or may not have been
Was the baby born with any purple markings / bruising on their face or head? __ No __ Yes
Any concerns about misshapen head at birth? __ No __ Yes

Post Natal & 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: 1 minute _____ /10 5 minutes _____ /10
Was the baby ever admitted into Neonatal Intensive Care? __ No __ Yes
If yes, for how long and why? _____
Was any medication given to the baby at birth? __ No __ Yes __ Unsure
If yes, what medication and why? _____
Was your child exclusively breastfed? __ No __ Yes _____Months
Was your child breast fed + formula fed? __ No __ Yes _____Months
Did your child show any sensitivities to formula (reflux, eczema, arching back, frequent spit up)? __ No __ Yes
What age did you introduce solid foods to your child? _____Months
Did you introduce cereal or grains within your child's first year? __ No __Yes
Did/Do you practice attachment parenting methods:
(cosleeping, kangaroo care, elimination communication, feeding on demand, extended breastfeeding etc) __ No __ Yes
Did your child spend excess time in any baby devices such as: bouncer seats, swings, bumbos, car seats etc?
__ No __ Yes, Which ones? _____

Physical Traumas

Has your child ever fallen from any high places? . . . . . __ No __ Yes _____
Has your child ever 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 _____
Does your child spend time using a tablet, computer or video games? __ Never __ Rarely __ Daily __ Several hrs/day
Does your child watch TV? . . . . . __ Never __ Rarely __ Daily __ Several hrs/day
Does your child exercise? . . . . . __ No __ Daily __ Weekly __ Seasonally
Does your child play contact sports? . . . . . __ No __ Daily __ Weekly __ Seasonally
Does your child sleep on their . . . . . __ Back __ Belly __ Sides (Both, Right, Left)
Does your child carry a backpack? . . . . . __ No __ Yes
Does it weigh less than 15% of their body weight? . . . . . __ No __ Yes
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

Have you chosen to vaccinate your child? __ No __ Yes, on a delayed schedule __ Yes, on schedule
Reason for vaccination: __ Informed decision __ Didn't know I had a choice __ It was recommended
Reaction(s) to vaccination: __ Fever __ Welt 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 been exposed to antibiotics? __ No __ Yes
If yes, how many doses in the past 6 months? _____ Reason _____
Were probiotics used at the same time as antibiotics? __ No __ Yes
Has your child been exposed to medications, including OTC: __ No __ Yes
If yes, which ones?_____
If yes, how many doses in the past 6 months? _____ Reason _____

How many glasses of water/day does your child have? . . . . . __ 0 __ 1-3 __4-6 __ 7-9 __ 10+
How any 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 __ Trying to eliminate from diet
Does your child eat dairy? . . . . . __ No __ Yes __ Trying to eliminate from diet
Does your child eat refined sugars? (white sugar, white bread, and pasta) . . . . __ No __ Yes __ Trying to eliminate from diet
Does your child eat boxed/frozen foods? . . . . . __ No __ Yes __ Trying to eliminate from diet
Do you choose organic foods? . . . . . __ No __ Yes If yes, which: __ Veggies __ Fruits __ Meats __ Grains __ All
Does your child eat any artificial sweeteners? (Splenda, Aspartame, Diet Soda, etc) __ No __ Yes
Does your child follow an other dietary restrictions? __ No __ Yes _____
Any food/drink allergies, sensitivities, intolerances? __ No __ Yes _____
Is your child exposed to second hand smoke? __ No __ Yes
Does your child take a probiotic daily? __ No __ Yes, _____ CFU's/day
Does your child take vitamin D3 daily? __ No __ Yes, _____ IU's/day
Does your child take Omega 3 Fish oils daily? __ No __ Yes, _____ mg/day __ Capsule __ Liquid
Other supplements or homeopathics?_____
Any other medication and their purpose? _____
_____
Do you have a plan with your medical doctor to wean yourself off of any long term medications? __ No __ Yes

Goals and Consent

Do you feel you child is developmentally appropriate for their age:
Intellectually: __ Yes __ No _____
Emotionally: __ Yes __ No _____
Physically: __ Yes __ No _____

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

Our goals are to provide a detailed assessment of your current health status and provide to you the resources for a highly engaged and healthy body which is functioning at absolute peak potential. Essential to this is a healthy nervous system functioning free from interference called subluxation. You've taken an important step for your health through a chiropractic evaluation!

Consent to Evaluation of a Minor Child
I _____ being the parent or legal guardian of _____
hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan and examination and x-rays if warranted. Any findings will be communicated before consenting to commencement of care, if appropriate.

_____ _____
Consenting Adult's Signature Date