



**Alamo Heights Chiropractic**  
HEALTH CENTER

**Alamo Heights Chiropractic Center**  
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*Pediatric*

Infants & Toddlers



**Practice Member Information**

File \_\_\_\_\_

Child's Name: \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_

Parent's/Guardian's Names: \_\_\_\_\_

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ May we leave a message? Yes No

Parent's Cell Phone: \_\_\_\_\_ May we leave a message? Yes No

Parent's 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: \_\_\_\_\_

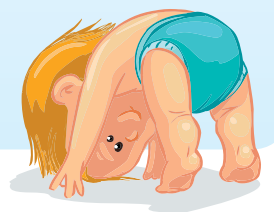
Name: \_\_\_\_\_

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 condition 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**.

### What signals has your child's body been communicating?

CURRENT  
PREVIOUS

Asthma  
Respiratory Tract Infections  
Sinus Problems  
Ear Infections  
Tonsillitis  
Strep Throat  
Frequent Colds / Croup  
Recurrent Fevers  
Eczema  
Rashes  
Allergies  
Food Sensitivities  
Digestive Problems

CURRENT  
PREVIOUS

Frequent Diarrhea  
Constipation  
Flatulence  
Headaches/Migraines  
Neck Pain  
Torticollis / Head Tilt  
Trouble Feeding on One Side  
Back Pain  
Growing Pains  
Scoliosis  
Red, Swollen, Painful Joint  
Colic  
Frequent Crying Spells

CURRENT  
PREVIOUS

Failure to Thrive / Slow Weight Gain  
Slow or Absent Reflexes  
Asymmetrical Crawling or Gait  
Weight Challenges  
Bed Wetting  
Sleep Problems  
Night Terrors  
Tip Toe Walking  
Regression of Milestones  
Seizures  
Tremors / Shaking  
ADD / ADHD  
Autism / PDD

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:

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? \_\_\_\_\_

Have you seen other health professionals regarding this complaint?

No if Yes, whom? \_\_\_\_\_

What treatment did they 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 \_\_\_\_\_

## 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 to induce / speed up labor: No Yes \_\_\_\_\_  
 Were your membranes ruptured by a medical professional? No Yes \_\_\_\_\_  
 Was your child at anytime during your pregnancy in an intra-uterine constricting position? No Yes Unsure  
 If yes, please describe: Breech Transverse Face / Brow presentation \_\_\_\_\_  
 Was your delivery vaginal or C-section? \_\_\_\_\_ If it was a C-section, was it planned or emergency? \_\_\_\_\_  
 If it was vaginal, was the baby presented: Head Face Breech \_\_\_\_\_  
 Were any of the following interventions used during delivery? 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? \_\_\_\_\_ Hours  
 How long was the second stage (the pushing phase) of the labor? \_\_\_\_\_ Hours  
 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 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 administered to Neonatal Intensive Care? No Yes \_\_\_\_\_  
 If yes, for how long and why? \_\_\_\_\_  
 Was any medication given to the baby at birth? Yes No Unsure \_\_\_\_\_  
 If yes, what medication and why? \_\_\_\_\_

### Child Health History *(Answer only those which are applicable)*

How many hours does your baby sleep between feedings? \_\_\_\_\_ Day \_\_\_\_\_ Night  
 Does your child have a preferred sleeping position? No Yes \_\_\_\_\_  
 Does your child have any feeding difficulties? No Yes \_\_\_\_\_  
 Is your child currently being breast fed? Yes: exclusively breastfed formula supplemented No  
 If no, how long was the baby breast fed? \_\_\_\_\_ weeks/months  
 Does your child have a one-sided breast preference? No Yes If yes, Prefer Left or Right \_\_\_\_\_  
 Does your child frequently spit up after feeding? No Yes \_\_\_\_\_  
 Does your child cry often? No Yes If yes, approximately how many hours per day? \_\_\_\_\_  
 Does your child pass a lot of intestinal gas? No Yes \_\_\_\_\_  
 Does your child frequently arch his/her head and neck backwards? No Yes \_\_\_\_\_  
 Has your child shown any sensitivities to foods either in your diet or their own? No Yes \_\_\_\_\_  
 Is your child exposed to cow's milk/dairy? No Yes, formula Yes, directly Yes, I drink it and breastfeed.

### Developmental History

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 \_\_\_\_\_



## Chemical Stressors

Have you chosen to vaccinate your child?    No    Yes, on a delayed or selective schedule    Yes, on schedule

Reason for vaccination:    Informed decision    Didn't know I had a choice    It was recommended

Reaction(s) 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 been exposed to antibiotics?    No    Yes

If yes, how many doses in 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 past 6 months? \_\_\_\_\_ Reason \_\_\_\_\_

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    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 like Splenda, Aspartame, AminoSweet, Diet Soda?    No    Yes

Does your child follow any 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? \_\_\_\_\_

## Goals & Consent

Do you feel your 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 child's current health status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You've taken an important step for your child's future through a chiropractic evaluation!

### Consent to Evaluation of a Minor Child

I \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_,  
(print name of consenting adult) (print name of minor)

hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, examination and x-rays if warranted. Any findings will be communicated before consenting to commencement of care, if appropriate.

\_\_\_\_\_  
Consenting Adult's Signature

\_\_\_\_\_  
Date