WHOLE FAMILY
CHIROPRACTIC

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St Paul, MN 55116

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Welcome!

Your first visit with us is an opportunity for us to learn all about you. It is a time for you to share with us about your health, your family and your goals.

Personal Information - Pediatric

Child Name _____ Today's Date _____/_____/_____

Child Birth Date _____/_____/_____ Biological gender: ◯ Male ◯ Female

Mother's Name _____ Father's Name _____

Are parents: ◯ Single ◯ Married/Partnered ◯ Widowed ◯ Divorced

# of Kids in family _____ How many at home? _____

Kids' names & ages: _____

Primary Contact for child: _____ Relation: _____

Phone: _____

Address _____

Number & Street City State Zip

Email Address _____

Has your child been to a chiropractor before? ◯ Yes ◯ No Approximate date of last visit ____/____/____

Dr.'s Name/City/State _____ Good results? ◯ Yes ◯ No

Is your child under care of any other doctor? Yes/No If Yes, the condition being treated for _____

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

Your child's favorite hobbies or interests _____

Labor and Delivery History

Did child's mother and/or your child experience any of the following during the labor/delivery

☐ Hospital birth	☐ Home birth	☐ Birth Center	☐ The labor was induced
☐ Long and/or difficult labor	☐ The delivery was rapid	☐ Placenta previa	☐ Forceps or suction cup used
☐ Elective c-section	☐ Emergency c-section	☐ Fetal distress	☐ Cord around the neck
☐ The child was premature (2+ weeks early)	☐ The child was a "blue baby"	☐ Breech birth	☐ Adoption Age brought home:_____

Please list reasons for any interventions/complications during labor and delivery _____

_____

Rank mother's general stress level (0-10) during pregnancy _____

Did mother smoke during pregnancy? ◯ Yes / ◯ No

Any illness of mother during pregnancy? ◯ Yes / ◯ No If yes, please explain _____

List any drugs/medications (including over-the-counter) taken during pregnancy _____

_____

Let's Find Out Why You're Here…

Reason for seeking chiropractic care _____

_____

Any other specific concerns? _____

If seeking chiropractic for a specific concern, has your child been treated for this concern before? Yes ◯ / No ◯

Please explain _____

When did this concern begin? _____

List all current medications and conditions being treated _____

_____

List any vitamins/herbs/homeopathics/other your child is taking _____

_____

Has your child received any vaccinations? ◯ Yes / ◯ No If yes, list any reactions _____

_____

Has your child received any antibiotics? ◯Yes /◯ No If yes, how many times and list reason

_____

List any past surgeries or hospitalizations and dates _____

_____

List any past accidents and dates _____

List any injuries _____

Has your child ever been under chiropractic maintenance care? _____

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

Any difficulty with breastfeeding? Explain. _____

Is/was your child formula fed? Yes ◯/ No◯If yes, how long? _____

Any difficulty with bonding? Yes◯/ No ◯ If yes, please explain _____

Any behavioural problems? Yes ◯/ No◯ If yes, please explain _____

Does your child have regular bowel/bladder movements? Yes ◯/ No◯

Quality of Life Inventory

If your child has experienced any of the following, please indicate by selecting **C** (Current), **P** (Past) or **CP** (Current and Past).

- ___ Fatigue
- ___ Diabetes
- ___ Fainting
- ___ Asthma
- ___ Anxiety
- ___ Cold Sweats
- ___ Weakness
- ___ Dizziness
- ___ Headaches
- ___ Migraines
- ___ Sinus problems
- ___ Frequent colds
- ___ Head injury
- ___ Serious illness
- ___ Meningitis
- ___ Heart problems
- ___ Loss of balance
- ___ Skin Conditions
- ___ Ulcers
- ___ Cancer
- ___ Digestion problems
- ___ Nervousness
- ___ Sleeping problems
- ___ Difficulty focusing
- ___ Seizures/Convulsions
- ___ Urinary problems
- ___ Mood swings
- ___ Low energy/tired
- ___ Allergies to foods
- ___ Environmental allergies
- Chronic ear infections/earaches
- Serious fall(s) or repetitive falls
- Illnesses with a high fever
- Trouble with bladder control
- Joint or muscle problems
- Nausea
- Neck or back problems
- Ringing in ears

Other_____

Let's Make Sure We're On the Same Page…

When an individual or family seeks and is accepted into a program of **function-based** chiropractic care, it is essential both parties are working toward the same objectives. We have one primary goal, and it is important that everyone understands our objective and the methods we will use to move toward that objective.

Your child's care in our center is not a substitute or alternative form of *medicine*. Medically-based care specializes in the *diagnosis* and *treatment* of specific symptoms, illness and disease. Our function-based chiropractic care specializes in helping people of all ages ensure that their spines and nerve systems are functioning as optimally as possible. This in turn allows their bodies to work the best they possibly can.

If during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Our focus is to improve your child's ability to function, therefore, moving it toward increased **health**, **wellness** and an **overall improved quality of life**.

If you are seeking care for the removal of a *specific* medical symptom or condition, we suggest you seek additional help from a symptom, illness, and disease orientated professional if you feel that our function-based approach will not be sufficient in progressively raising you to the levels of health, wellness and quality of life you desire for yourself and your family.

I, _____, parent of _____have read and understand the above statement and I hereby give permission for Whole Family Chiropractic to continue with my child's initial consultation and assessment. I also agree to return at a later date to allow Whole Family Chiropractic to report their findings and recommendations to me. By agreeing to this, I am in no way obligated to follow the advice given to me in the report of findings.

Parent Signature _____ Date ____/____/____

We look forward to helping you maximize your experience and expression of health and life!