CHILD INTAKE INFORMATION

Child's Name: _____ **Date of Birth:** _____/_____/_____
Home Address:_____
Home Telephone: _____ Parent Cell: _____
Family Emergency Contact (Name & Number): _____
Primary Doctor: _____ Phone: _____
Other Doctor: _____ Phone: _____
Other Doctor: _____ Phone: _____
Has your child been under chiropractic care before? If yes, date of last adjustment: _____

CONSENT FOR CARE

- *I hereby give consent & authorize A Wellness From Within, LLC to render chiropractic care, perform diagnostic tests & & other adjunctive therapies or treatments to my minor (son/daughter). This authorization also extends to other doctors & office staff in aiding the care of the child at the doctor's discretion.*
- *Under the conditions of divorce, separation or other legal authorization, the consent of the former spouse/guardian is not required. I will notify this office immediately if my authorization as guardian is revoked or modified in any way.*
- *You are responsible for all services rendered by this office. Please speak with our office if you need a payment plan. Unpaid balances may be subject to 35% fee if they go to collections. If your insurance company DOES pay for a service you have been charged for, we will credit your account for that amount. Payment for care rendered is due at time of service.*

LEGAL GUARDIAN: _____ **DATE:** _____

MAJOR HEALTH COMPLAINTS

Primary/Main Concern for Child: _____
Minor/Other Concern for Child: _____
Minor/Other Concern for Child: _____
Minor/Other Concern for Child: _____
Please list other treatments your child has undergone including any: ***medication,illnesses, fractrures & surgery(s)***:
_____
Frequency of Complaint: ***Constant*** ***Intermittent*** ***Occasional*** ***Cyclical***
Date Problem Started: ____/____/_____
Onset began: ***Sudden*** ***Gradual*** ***Accident/Incident***: _____
Duration of problem or episode: _____***Hours*** _____***Days*** _____***Weeks*** _____***Months*** _____***Years***
Prior occurrences in the past or had before: _____
Aggravating Factors (makes worse):_____
Relieving Factors (makes better): _____
How does the problem affect your child's daily activities and overall function: _____
Other health concerns? _____

HISTORY OF BIRTH & DEVELOPMENT

Hospital / Birthing Center: ***Medical | Mid-wife | Doula | Home Birth*** Gestation Period: ___***/40 weeks***
Was the birth assisted? ***YES | NO*** If yes: ***Forceps | Vacuum Extraction | C-section | Induced Labor***
Medication given to Mom during pregnancy or birth? ***YES | NO*** If yes, please explain: _____
Was labor and delivery normal? If no, please explain complications: _____
Normal APGAR at birth and after? If no, please explain: _____
Normal Sleeping patterns? If no, please explain possibilities or other diagnosis: _____
Other health problems, family history, or abnormal development (response to sound, crawl, interaction, talk, sight): _____
_____

The following information is very important, no judgments will be made. Many problems that chiropractors work with are caused by STRESS! These can be chemical (toxins), psychological (thoughts & emotions), or physical (traumas).

Chemical Stressors

During pregnancy, did the mother:

1. Smoke? Yes | No
2. Drink alcohol? Yes | No
3. Take supplements/vitamins? Yes | No
4. Take drugs/medications? Yes | No
If yes, what?_____
5. Become ill? Yes | No
If yes, what?_____
5. Receive ultrasounds? Yes | No
If yes, how many? _____
6. Receive invasive procedures? Yes | No
If yes, what?_____

Was/Is your child breast fed? Yes | No
If yes, for how long?_____
At what age was:
a. Formula introduced/ Brand?_____
b. Goat/ Cow's milk?_____
c. Solid foods? _____
Did your child receive vaccinations? Yes | No
If yes, which ones:_____
Did your child react to them? Yes | No
If yes, explain:_____
Has your child had antibiotics? Yes | No
If yes, how many treatments & why?_____
Any pets at home? Yes | No
Any smokers at home? Yes | No
If yes, how much?_____

Psychological Stressors

Any difficulties with lactation? Yes | No
Any problems bonding? Yes | No
Does your child seem normal to you? Yes | No
Does the child have any behavior problems? Yes | No
If yes, what?_____
Does your child have sleep problems? Yes | No
If yes, specify (bedwetting, sleep walking, terrors:_____
Did your child go to daycare? Yes | No
From what age?_____ **yrs**
Average no. of hours of TV/Computer per day/wk? _____/_____**hrs**

Traumatic Stressors

Any evidence of trauma during birth? Yes | No
If yes, explain: _____
(Bruises | Odd shaped head | Stuck in birth canal | Fast or long birth, Respiratory Depression , Cord around neck)
Any falls/accidents during pregnancy? Yes | No
Has the child had any major falls since birth? Yes | No
If yes, did the child need stitches or cause a fracture? Please describe: _____
Any hospitalizations? Yes | No
If yes, please explain: _____
Does your child play sports? Yes | No
Number of hours per week? _____ **hrs**
Age child began _____ **yrs**
Weight of school backpack? _____ **lbs**
Approx. Hours spent at play per week? _____ **hrs**