THE GET WELL CENTER
CHIROPRACTIC PEDIATRIC INFORMATION

Why this form is important:

Our office focuses on your child's ability to be healthy. Our goals are to first address the issues that brought you and your child to this office, and second, to offer the opportunity to improve your child's health potential in the future. Everyday life activities include events that can cause damage to your nervous system (termed **subluxations**). This damage builds up layer upon layer and science has shown that **you may not even be aware of it.**

Please take a few moments and complete this questionnaire as thoroughly as possible. Your answers will help us to determine if our care will help your child to reach his/her health goals. If we do not sincerely believe that your child's condition will respond satisfactorily to the care we are able to provide, we will be honest and up front in telling you so and will work with you in an attempt to refer you to a more apropriate health care provider. If you require any help with this form, please ask and our staff will be happy to assist you.

CHILD'S INFORMATION: (PLEASE PRINT)

Child's Name:____________________________________ Date of Birth:__________________
Home Address: ______________________________City:______________ Postal Code:______
Home Phone Number: _______________________

PARENT'S/GUARDIAN'S INFORMATION: (PLEASE PRINT)

Mother's/Guardian's Name:_____________________Father's/Guardian's Name_________________________
Home Number:___________________________________ Work Number:____________________
E-Mail: ____ Cell Number:_____________________
Family MD and Phone Number:____
How were you referred to our office:____

Research is showing that many of the health challenges that occur later in life have their origins during the developing years, some starting at or before birth. We need to know what your child's layers of damage contain, so we ask you to carefully and completely fill out this detailed and important form.

Labor and Delivery: (Please check all appropriate responses.)

_____Hospital with doctor _____Hospital with Midwife _____Home with Midwife
_____Breach _____Caesarian _____Fetal Monitor Used _____Medications
_____Forceps _____Length of delivery:____
_____Complications. Please describe: ____
____

Prenatal & Child History

Number of Ultrasounds given during pregnancy: ____
Duration of Pregnancy in weeks: ____________ APGAR Scores at birth:____________
Please check any problems present at birth: _____Jaundice _____Cyanosis _____Choking
_____Other:____
Please check any of the following which apply to the child after birth:
_____Medication _____Artificial Feeding _____Vitamin K Injection _____Surgery
_____Erythromycin _____Circumcision _____Other:___________________________

Nutrition

Please check if the child has received any of the following:
_____Breast Milk _____Commercial Formula _____Cow's Milk _____Goat's Milk
_____Solid Food _____Sweets _____Fruit Juice _____Vitamins _____Medication
_____Other: ____

Developmental History

If your child is <2, please indicate which of the following milestones s/he has reached:
_____Holding head up _____Sits up _____Crawls _____Stands alone _____Walks alone
According to The National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ie, bed changing table, downstairs, etc). Was this the case with your child? _____Yes _____No Please describe the circumstances:_______________________
____

Has your child ever been involved in any high impact or contact type sports (ie, hockey, soccer, football, skateboarding, gymnastics, baseball, martial arts, etc?)
_____Yes. _____ No. Please List:____

Has your child ever been treated on an emergency basis? _____Yes. _____No.
Please describe: ____
Other injuries or falls not described above? _____Yes. _____ No. Please list: ________________
____
Prior surgery? _____Yes _____No Please list: ____
If applicable, please state age of first menstrual period: ___________________________________

Is your child vaccinated or have you chosen not to vaccinate? If your child has been vaccinated, please list any reactions: ____

Childhood Diseases: Please indicate if your child has had any of the following:
_____Measles(Rubeola) _____Mumps _____Rubella(German Measles)

_____Pertussis(Whooping Cough) _____Chicken pox _____Other: ________________

Important Note:
Chiropractic has helped children with many health problems like asthma, allergies, bed-wetting (nocturnal enuresis), colic, ear infections (acute and chronic), headaches, scoliosis, etc. Chiropractic care has also been shown to help prevent these and other illnesses from occurring and ensure children have a healthier life. To optimally prevent these conditions, a child should have a chiropractic spinal check-up as soon after birth as possible. It is therefore important to get your other children's spines checked. Please let us know what times are best for your schedule and we will gladly set up these appointments.

I hereby authorize the Doctor to examine and treat my child's condition as he deems appropriate through the use of Chiropractic Health Care (consult, thorough Chiropractic examination and chiropractic adjustments) and I give authority for these procedures to be performed, I have been informed of the Clinic's financial policy and agree that I am responsible for all bills incurred at this office.

Patient/ Guardian's Signature: _________________________________ Date: ______________

Dedicated to maximizing the health potential of you and your family

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