

Good Vibrations Family Chiropractic

Child Wellness Assessment

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Email Address _____

Home Phone _____ Business Phone _____

Date of Birth M _____ /D _____ /Y _____

Name of parents _____

Name of siblings and ages _____

Have you seen a chiropractor before? No ___ If so when? _____

Does your family see a chiropractor? _____

What would you like your child to receive from care in this office?

What is your level of commitment to you and your child's life and well-being? _____

How did you find out about Good Vibrations Chiropractic Chiropractic?

Is there anything about your child's Nerve System and Spine or health we should know about? _____

Additional Comments: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child. Parent/Guardian Signature _____ Date _____

History of birth and Labour

Name of Obstetrician/Midwife _____

Name of MD/Pediatrician _____

Type of birth? Cephalic (head first) _____

Breech (feet first) _____

Occiput Posterior (facing forward) _____

Location of birth? _____

Birth Assistants? (MD, Midwife, Doula) _____
Any assistance required during birth? (Forceps, Vacuum extraction, Cesarean) _____
Any Complications during birth? _____

What was the child's gestational age at birth? _____ weeks
Birth weight _____ Birth length _____
Congenital anomalies/defects present? _____

Was your child subjected to any of the following?
Silver Nitrate eye drops _____ Incubation (how long) _____
Vitamin K injection _____ Hepatitis injection _____
Separation from mother (how long) _____

Was your child alert and responsive within 12 hours of delivery? Explain _____

Mother's position during labour (back, side, sitting, standing, other) _____

Was labour induced? _____
Did the mother receive any drugs before, during, or after the birth process? (Epidural, Morphine, other) _____

Did the mother have an episiotomy? _____
Duration of the labour and delivery _____

Growth and Development

At what age did your child:

Follow an object _____	Respond to sound _____
Hold up head _____	Vocalize _____
Sit unassisted _____	Teethe _____
Crawl _____	Walk _____

Do you consider your child's sleeping pattern normal? Explain _____

Any health problems on the mother's side of the family? (cancer, diabetes, heart disease, etc.) _____

On the father's side _____

With siblings _____

Chemical stressors

Any trauma/illness during the pregnancy? _____

During pregnancy did the mother: Cigarette Smoke (first or second hand, if so how much) _____
Consume Alcohol (if so how much) _____
Take supplements (if so please list) _____
Take drugs (if so please list) _____
Receive ultrasounds or other radiation _____
Receive any invasive procedures during the pregnancy (amniocentesis, etc.) _____

Was your child breast fed? (until what age) _____
Introduced formula at what age? _____
Introduced cows milk at what age? _____
Introduced solid foods at what age? (types) _____

Please list your child's history of antibiotic use and types _____

Please list your child's history of vaccinations and the age given _____

Reason for vaccinations? _____
Any negative reactions? _____
Any smokers in the home? (Please list) _____
Any pets in the home? (Please list) _____

Psychosocial stressors

Did the mother have any problems with lactation? _____

Any problems with bonding with your child? _____
Any behavioral problems? _____
Number of hours your child sleeps? _____
Any night terrors, sleep walking, difficulty sleeping? _____

Average number of hours your child watches television each week, if any _____

Do you feel that your child's social and emotional development is normal for their age? (Please explain) _____

Physical stressors

Any traumas for the mother during pregnancy? (falls, accidents, etc.) _____

Any evidence of birth trauma to your child? Check all that apply:
Bruising _____ Stuck in birth canal _____
Odd shaped head _____ Respiratory depression _____
Fast or excessively long birth _____ Cord around neck _____

Any child falls from couches, beds, change tables, etc? _____

Any child traumas resulting in bruises, fractures, or stitches? _____

Any child hospitalizations or surgeries? _____

Any sports participation and age began? (list sports and number of hours each week) _____

Approximate hours of playtime each week _____

Is a school backpack used? (Heavy or Light) _____

Health Goal Planning

Top 5 Health Goals

In order for me to understand your child's needs and create a more complete direction for their health, please share your top 5 health goals for your child.

1.

2.

3.

4.

5.