Good Vibrations Family Chiropractic

Child Wellness Assessment

First Name _____ Last Name _____

Address _____
City _____ State _____ Zip Code_____
Email Address _____
Home Phone _____ Business Phone_____

Date of Birth M_____/D_____/Y_____
Gender:_____
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 Family 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_____
Witnessed Signature_____

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)_____

Additional comments:_____

_____

_____

_____

_____

Health Goal Planning

Top 5 Health Goals

In order for us 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.

Good Vibrations Chiropractic

TERMS OF ACCEPTANCE

When a person seeks chiropractic care and we accept a person for such care, it is essential for both to be working for the same objective. The following definitions help to clarify some of the fundamentals of chiropractic.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the twenty-four vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a decrease of the body's natural ability to express its maximum health potential.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

We offer to provide chiropractic care to correct the vertebral subluxation. Our practice objective is to eliminate major interference of the nervous system for the expression of the body's natural ability to heal and grow. We may use other procedures to help your body maintain the benefits of the adjustments. If during the course of a chiropractic neuro-spinal analysis we encounter non-chiropractic or unusual findings, or any known risk of bodily harm, we will advise you to seek the services of another healthcare specialist.

At Good Vibrations Chiropractic, health is a dedicated and active process that is achieved through our partnership with the objective of optimizing your health and life.

I, _____ have read and fully understand the above statements.

All questions regarding the Chiropractor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

_____ _____

(Signature) (Date)

Consent to evaluate and adjust a minor child:

I, _____being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.