Well Within
CHIROPRACTIC & WELLNESS

Child's Name: _____ Date: _____

Child's DOB: _____ Age: _____ Child's Height: _____ Weight: _____

Sex: ☐ Male ☐ Female Parent/Guardian Name: _____

Home Address/Zip: _____

Parent's Cell Number: _____ Alt. Phone Number: _____

Parent's E-mail: _____ Appointment Reminders: ☐ Text ☐ Email

How did you hear about us? _____

Emergency Contact Name: _____ Relationship to Child: _____

Phone number: _____ Alt. Phone number: _____

Family Doctor Name & Clinic: _____

Prof. Designation: _____ Date/Reason of Last Visit: _____

Other Healthcare Professionals: Medical Specialist, Naturopathic Doctor, Counselor, etc.

Name: _____ Prof. Designation: _____

Date/Reason for last visit: _____

Name: _____ Prof. Designation: _____

Date & reason for last visit: _____

Has your child received previous chiropractic care? ☐ Yes ☐ No

Why have you decided to have your child evaluated by us?

☐ He/She is continuing ongoing care from another chiropractor.

☐ I recently had my spine checked and understand the value in getting my child checked.

☐ I have concerns about his/her health and I'm looking for answers.

☐ He/She has a specific condition and I've learned that chiropractic may be able to help

☐ I want to improve my child's immune function

Do you have a specific concern that brings you in?

☐ No - We want a nervous system and general wellness assessment for optimal health

☐ Yes - If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? _____

How long has your child been experiencing this? _____

Is it getting better, worse or staying the same? _____

Was the onset sudden or gradual? _____

Who, if anyone else, have you seen regarding this complaint? _____

What treatment did they use? _____

Has your child taken any medication for this complaint? ☐ No ☐ Yes, If so which: _____

_____

Has your child ever experienced this complaint before? ☐ No ☐ Yes

Did they receive any treatment at that time? ☐ No ☐ Yes Had x-rays taken for it? ☐ No ☐ Yes

What is your primary goal for your child at our clinic?_____

_____

Symptoms and Health History

Current / Previous		Current / Previous		Current / Previous	
☐ ☐	Asthma	☐ ☐	Flatulence	☐ ☐	Failure to Thrive / Slow Weight Gain
☐ ☐	Respiratory Tract Infections	☐ ☐	Yeast Infections	☐ ☐	Slow/Absent Reflexes
☐ ☐	Sinus Problems	☐ ☐	Acid reflux	☐ ☐	Asymmetrical Crawl/Gait
☐ ☐	Ear Infections	☐ ☐	Ulcers	☐ ☐	Diabetes - Type: ☐1 ☐2
☐ ☐	Tonsillitis	☐ ☐	Appendicitis	☐ ☐	Weight Challenges
☐ ☐	Strep Throat	☐ ☐	Anemia	☐ ☐	Bed Wetting
☐ ☐	Thrush	☐ ☐	Bleeding Disorder	☐ ☐	Sleep Problems
☐ ☐	Frequent Colds / Croup	☐ ☐	Headaches/Migraines	☐ ☐	Night Terrors
☐ ☐	Recurrent Fevers		-How often:_____	☐ ☐	Tip Toe Walking
☐ ☐	Chicken Pox	☐ ☐	Neck Pain	☐ ☐	Regression Milestones
☐ ☐	Mononucleosis	☐ ☐	Torticollis / Head Tilt	☐ ☐	Seizures
☐ ☐	Eczema	☐ ☐	Trouble Feeding on One Side	☐ ☐	Tremors / Shaking
☐ ☐	Rashes	☐ ☐	Back Pain	☐ ☐	ADD / ADHD
☐ ☐	Allergies	☐ ☐	Growing Pains	☐ ☐	Autism / PDD
☐ ☐	Allergy shots	☐ ☐	Scoliosis	☐ ☐	Psychiatric care
☐ ☐	Digestive Problems	☐ ☐	Red, Swollen, Painful Joint	☐ ☐	Other: _____
☐ ☐	Frequent Diarrhea	☐ ☐	Colic		_____
☐ ☐	Constipation	☐ ☐	Frequent Crying Spells		

Prenatal Profile

☐ Adopted ☐ Prenatal History unknown ☐ Birth history unknown

Complications during pregnancy: ☐ No ☐ Yes (brief description:_____

_____

Ultrasounds during pregnancy: ☐ No ☐ Yes - If so, how many: _____

Medications during pregnancy: ☐ No ☐ Yes, If so which ones and how often? (include OTC):

_____

Exposure to alcohol, cigarettes or second hand smoke during pregnancy: ☐ No ☐ Yes

Birth Experience Location of Birth: ☐ Home ☐ Hospital ☐ Birthing Centre ☐ Other: _____

Birth Attendants: ☐ Doula ☐ Midwife ☐ GP ☐ OB ☐ Other: _____

Medications during labor / delivery (including IV antibiotics) ☐ No ☐ Yes Was Pitocin used? ☐ No ☐ Yes

Were your membranes ruptured by a medical professional? ☐ No ☐ Yes

Was your child at anytime during your pregnancy in an intra-uterine constraining position? ☐ No ☐ Unsure

☐ Yes - If yes, please describe: ☐ Breech ☐ Transverse ☐ Face / Brow presentation

Delivery was : ☐ Vaginal - If vaginal, was the baby presented: ☐ Head ☐ Face ☐ Breech

☐ C-section - If a C-section: ☐ Planned ☐ Emergency

Interventions used during delivery, if any? ☐ Forceps ☐ Vacuum extraction ☐ Other_____

Were there any complications during delivery? ☐ No ☐ Yes - If yes, please specify: _____

_____

How long was the labor from the first regular contractions to the birth? ____ Hrs

Length of second stage (pushing phase) of the labor? ____ Hrs

Any purple markings / bruising on baby's face or head at birth? ☐ No ☐ Yes

Any concerns about misshapen head at birth? ☐ No ☐ Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? _____Wks _____Days Birth weight ____lbs ___oz

Birth length: ____ inches If known, APGAR scores at: 1 minute ____/10 5 minutes ____/10

Any time spent in Neonatal Intensive Care? ☐ No ☐ Yes - If yes, for how long? _____ Why?_____

_____

Was any medication given to the baby at birth? ☐ No ☐ Unsure ☐ Yes, the following medications and why:

_____

Exclusively breastfed? ☐ No ☐ Yes, for _____mos Breastfed + formula fed? ☐ No ☐ Yes, for _____mos

Any sensitivities to formula (reflux, eczema, arching back, frequent spit up)? ☐ No ☐ Yes

Age solid foods introduced? _____ mos Was child introduced to cereal/grains in 1st year? ☐ No ☐ Yes

Did/Do you practice any attachment parenting methods: ☐ Kangaroo care ☐ Elimination communication

☐ Cosleeping ☐ Feeding on demand ☐ Extended breastfeeding ☐ Other: _____

Significant time spent in any baby devices such as, bouncer seats, swings, bumbos, car seats, etc.)?

☐ No ☐ Yes: _____

Physical Traumas

Has your child ever fallen from any high places? ☐ No ☐ Yes: _____

Has your child been involved in a motor vehicle accident or near miss? ☐ No ☐ Yes: _____

Has your child been seen on an emergency basis? ☐ No ☐ Yes: _____

Has your child broken any bones? ☐ No ☐ Yes: _____

Has your child had any previous hospitalizations? ☐ No ☐ Yes: _____

Has your child had any previous surgeries? ☐ No ☐ Yes: _____

Lifestyle Factors

Child's frequency of tablet, computer or video games use: ☐Never ☐Rarely ☐Daily ☐Several hrs/day

Child's TV watching frequency: ☐Never ☐Rarely ☐Daily ☐Several hrs/day

Child's exercise frequency: ☐Never ☐Rarely ☐Daily ☐Several hrs/day

Does your child play contact sports? ☐Never ☐Rarely ☐Daily ☐Several hrs/day

Does your child sleep on their: ☐Back ☐Belly ☐Sides (☐both, ☐right, ☐left)

Does your child carry a backpack? ☐No ☐Yes Approximate weight of backpack: _____lbs

Do they wear their backpack on 2 shoulders? ☐No ☐Yes ☐Sometimes

Does your child show excessive or uneven shoe wearing out? ☐No ☐Yes

Does your child wear custom orthotics? ☐No ☐Yes, For what purpose?_____

Chemical Stressors

Has your child been vaccinated? ☐No ☐Yes, on a delayed or selective schedule ☐Yes, on schedule

Reason for vaccination: ☐Informed decision ☐Unaware of choice to do so or not ☐It was recommended

Reaction(s), if any, to vaccination: ☐Fever ☐Welt at injection site ☐Rash ☐Diarrhea ☐Fatigue

☐Prolonged Cry ☐Seizures ☐Developmental Regression ☐Other_____

Does your child receive annual flu shots? ☐No ☐Yes (informed decision) ☐Yes (recommended by MD)

Has your child taken antibiotics? ☐No ☐Yes - Doses in past 6 months: ____

Reason(s):_____ Were probiotics taken concurrently? ☐No ☐Yes

Any other medications taken, including OTC: ☐No ☐Yes: _____ For _____

How many glasses of water/day does your child have? ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10 +

How many glasses of cow's milk, juice and soda/day does your child have: ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10 +

Does your child eat: Gluten? ☐No ☐Yes ☐Decreasing it in diet ☐Not sure

Does your child eat dairy? ☐No ☐Yes ☐Decreasing it in diet

Does your child eat refined sugars (white sugar), white bread and pasta? ☐No ☐Yes ☐Decreasing in diet

Does your child eat boxed/frozen foods? ☐No ☐Yes ☐Decreasing in diet ☐Not sure

Does your child eat any artificial sweeteners like Splenda, Aspartame, Diet Soda? ☐No ☐Yes

Does your child follow any other dietary restrictions? ☐No ☐Yes: _____

Any food/drink allergies, sensitivities, intolerances? ☐No ☐Yes: _____

How much of your food is organic? ☐None ☐Some ☐All

Is your child exposed to secondhand smoke? ☐No ☐Yes

Supplements/Other

Omega 3 Fish Oils? ☐No ☐Yes ____mg/day ☐Caps ☐Liqui

Does your child take: Vitamin D3? ☐No ☐Yes, ____ IU's/day Probiotics? ☐No ☐Yes, ____ CFU's/day

Other supplements or homeopathics?_____

Do you feel your child is developmentally appropriate for their age:

Intellectually: ☐Yes ☐ No Emotionally: ☐Yes ☐ No Physically: ☐Yes ☐ No