

### Pediatric/Youth Health Profile (Ages 12 and under)

\*Please do your best to fill out *everything* on this intake form. It is important that I understand past and current stressors that may have affected and could possibly continue to affect your child physically, emotionally, mentally, chemically, and spiritually. It is important for me to know the following information, even if it may not seem relevant to the reason for which you came in for care. Please know that I value your time and only aim to provide you the best care possible. Thank you for choosing Lotus of Life Chiropractic!

**Check type of care desired:**  Temporary Relief  Stabilization  Family Health/ Prevention  Doctor's Advice

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Parent's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Parent's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Email \_\_\_\_\_

Birth Weight \_\_\_\_\_ Birth Length \_\_\_\_\_ Current Weight \_\_\_\_\_ Current Height \_\_\_\_\_

Siblings' Names and Ages \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

### Current Concerns

What is the reason for your appointment? \_\_\_\_\_

When did this situation or concern first begin? \_\_\_\_\_

Is this related to an  auto accident  other injury (\_\_\_\_\_)

Have you done anything for or gotten any advice or treatment for this issue?  Yes  No

Explain: \_\_\_\_\_

Result: \_\_\_\_\_

What activities aggravate the condition/pain? \_\_\_\_\_

What activities alleviate the condition/pain? \_\_\_\_\_

Does it affect  school /  decision making /  exercise or play/  attitude, mood /  sleep?

Are there any other health concerns that are important to you? \_\_\_\_\_

### Chiropractic History

Does your family currently receive chiropractic care? Y N If no, have they in the past? Y N

Has your child ever been adjusted? Y N Doctor or Office's Name: \_\_\_\_\_

When? \_\_\_\_\_ Duration of care: \_\_\_\_\_

Reason for visit: \_\_\_\_\_ Result: \_\_\_\_\_

Technique used: \_\_\_\_\_ Last Adjustment: \_\_\_\_\_

**Developmental History**

**Mom's Pregnancy: check all that apply**

Tobacco  Alcohol  Medications  Recreational drugs  Special Diet

Falls/injuries  Abuse (Physical, sexual, or emotional)  Complications

Details of any checked: \_\_\_\_\_  
\_\_\_\_\_

**Birth: check all that apply**

Third Trimester Presentation: Vertex  Breech  Transverse  Face/Brow

Type of Birth: Vaginal  Forceps  Cesarean  Suction Cup or Vacuum

Interventions: Pitocin  Epidural  Ruptured Membranes  Episiotomy

Delivery Location: \_\_\_\_\_ OB/Midwife: \_\_\_\_\_

Pregnancy/Birth Story: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Developmental History:**

Breast Fed: How Long or Why Not? \_\_\_\_\_

Formula Fed: Dairy  Soy  Why formula fed? \_\_\_\_\_

Allergies: Foods \_\_\_\_\_ Medicines \_\_\_\_\_ Other \_\_\_\_\_

Food Sensitivities \_\_\_\_\_

Physical, emotional, or sexual abuse: \_\_\_\_\_

Nightmares or Night Terrors? Yes No Crawled (normally) before walking? Yes No N/A

Shoulder or elbow dislocation? Yes No Played in a hanging/bouncy swing (Johnny Jump-Up)? Yes No

Can they currently:  Sit Independently  Crawl Normally  Stand Independently  Walk Independently

**Females:** Menarche (1<sup>st</sup> menstrual cycle) Yes No If yes, Age: \_\_\_\_\_ Cramps/PMS? Yes No

**Chemical History:**

Vaccinations:  None  Select (list below)  Delayed, Full Schedule  Regular, Full Schedule

Past over-the-counter and prescription drugs (type and reason): \_\_\_\_\_

Current over-the-counter and prescription drugs (type and reason): \_\_\_\_\_

Current vitamins and supplements (type and reason): \_\_\_\_\_

**Health History**

**Mark each they have had in the past or have now. Put "P" for past and "N" for now.**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Ear Infections/Aches     | <input type="checkbox"/> Colds/Flu                  | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Sinus/Allergies          | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Eczema/Skin Condition | <input type="checkbox"/> Colic         |
| <input type="checkbox"/> Digestive problems       | <input type="checkbox"/> Changes in bowel/bladder   | <input type="checkbox"/> Reflux/Gassy          | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> Concussion/Head injury   | <input type="checkbox"/> Neck or Back pain          | <input type="checkbox"/> Heart/Valve Issues    | <input type="checkbox"/> Seizures      |
| <input type="checkbox"/> Motor Integration Issues | <input type="checkbox"/> Sensory Integration Issues | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> ADD/ADHD      |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Bed Wetting           | <input type="checkbox"/> Hernia        |
| <input type="checkbox"/> Muscle pain              | <input type="checkbox"/> Growing pains              | <input type="checkbox"/> Arm problems          | <input type="checkbox"/> Leg problems  |
| <input type="checkbox"/> Poor posture             | <input type="checkbox"/> Scoliosis                  | <input type="checkbox"/> Walking trouble       | <input type="checkbox"/> Broken bones  |
| <input type="checkbox"/> Surgery                  | <input type="checkbox"/> Sports Injury              | <input type="checkbox"/> Auto Accident         |  |
| <input type="checkbox"/> Other: _____             |   |  |  |

**Has your child experienced any of the following traumas?**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Fall in Baby Walker     | <input type="checkbox"/> Fall off Bed or Couch | <input type="checkbox"/> Fall from Crib | <input type="checkbox"/> Fall from Highchair                 |
| <input type="checkbox"/> Fall off Changing Table | <input type="checkbox"/> Fall down Stairs      | <input type="checkbox"/> Fall off Swing | <input type="checkbox"/> Fall off Slide or Monkey Bars (etc) |

**Fill in appropriate age if child has ever been diagnosed with any of the following.**

- |                       |                        |
|-----------------------|------------------------|
| Chicken Pox: _____    | Rubella: _____         |
| Mumps: _____          | Rubeola: _____         |
| Whooping Cough: _____ | Other: _____ age _____ |

**Child's Physician** (office and Doctor's name): \_\_\_\_\_

**Past Activities and Sports:** \_\_\_\_\_

**Current Activities and Sports:** \_\_\_\_\_

**Child's Diet / Mom's Diet if Breastfeeding**

	<u>Daily/High</u>	<u>Weekly/Moderate</u>	<u>Monthly or less/Low</u>	<u>None/Never</u>
Dairy (milk, yogurt, cheese)	_____	_____	_____	_____
Meat	_____	_____	_____	_____
Vegetables	_____	_____	_____	_____
Fruit	_____	_____	_____	_____
Gluten (flour, wheat, pasta)	_____	_____	_____	_____
Soy	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Soda/Energy Drinks	_____	_____	_____	_____
Fast food	_____	_____	_____	_____
Water	_____	_____	_____	_____

*\*Adequate (high) water intake means urine runs clear to only slightly yellow.*

Circle all that apply if mom is breastfeeding: caffeine, coffee, tea, alcohol, tobacco, medications of any type

**Household Habits**

Do you filter your drinking/cooking/shower water? Yes No \_\_\_\_\_

Do you eat organic foods? Yes No \_\_\_\_\_

Do you use organic health products (soaps, shampoos, detergents)? Yes No \_\_\_\_\_

Do you filter your air at home? Yes No \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Participant Consent Form**

When a participant seeks chiropractic health care and we accept a participant for such care, it is essential for both to be working toward the same objectives. It is important that each participant understand both the objectives and the methods that will be used to attain said objectives. This will prevent any confusion or disappointment. You have the right, as a participant, to be informed about the condition of your health and the recommended care and management to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

**Chiropractic** is a science, art and philosophy that concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health.

**Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. Therefore, symptoms are NOT a valid measure of health.

**Subluxation** is the physical manifestation of an un-integrated life experience. When one or more of the 24 vertebrae of the spinal column are misaligned, the system as a whole is affected: structurally, chemically, and tonally. This results in interferences to nerve system function, leading to tightened muscles and taught ligaments, therefore leading to a decrease in the body's overall, healthy performance.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce subluxation. Our chiropractic method of correction is by specific adjustments of the spine and related structural components. Adjustments are usually done by hand but may be performed by handheld instruments or specialized tables.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I will call the office if I have any questions or if any problems arise before each scheduled follow-up visit. I have read and understand all of the above statements.

**I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**