

Pediatric/Youth Updated Health Profile

*Please do your best to fill out *everything* on this intake form. It is important that I understand past and current stressors that may be affecting 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 _____ Age _____

Parent's Name _____ Work Phone _____ Cell _____

Parent's Name _____ Work Phone _____ Cell _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Email _____

Current Weight _____ Current Height _____

Current/ Updated Developmental History – please only mark changes or updates since last exam

Breast Fed _____ How Long or Why Not? _____ Formula Fed _____ Dairy _____ Soy _____

Allergies: Foods _____ Medicines _____ Other _____

Food Sensitivities _____

Accidents/Falls: _____

Surgeries: _____

Physical, emotional, or sexual abuse: _____

Nightmares or Night Terrors Yes No / Crawled before walking? Yes No / Special Diet? Yes No

Shoulder or elbow dislocation Yes No / Played in a hanging/bouncy swing? Yes No

Females: Menarche (1st menstrual cycle) Yes No If yes, Age: _____ Cramps? Yes No

Health History – please read directions before completing section

Mark all that apply with (S) for Same/No Change, (I) for Improved, (R) for Resolved, (N) for New Concern

<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Frequent infections	<input type="checkbox"/> Respiratory disorder/disease
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma	<input type="checkbox"/> Eczema/Skin Condition
<input type="checkbox"/> Nervous disorder	<input type="checkbox"/> Digestive problems	<input type="checkbox"/> Headaches (____x/____)
<input type="checkbox"/> Changes in bowel/bladder	<input type="checkbox"/> Concussion/Head injury	<input type="checkbox"/> Neurological issues
<input type="checkbox"/> Decrease Range of Motion	<input type="checkbox"/> Acid Reflux/Frequent Gas	<input type="checkbox"/> Colic or Excessive Moodiness
<input type="checkbox"/> Motor Integration Issues	<input type="checkbox"/> Sensory Integration Issues	<input type="checkbox"/> Learning Issues/Disabilities
<input type="checkbox"/> Other: _____		

Mark if child has been diagnosed with any of the following since the last exam.

Chicken Pox: age _____ Rubella: age _____ Mumps: age _____

Rubeola: age _____ Whooping Cough: age _____ Other: _____ age _____

Chemical History (since last exam)

Vaccinations: None _____ / Some (please list below) _____ / Delayed Schedule _____ / Full Schedule _____

Number of doses of antibiotics you have given your child since their last exam: _____
 For what? _____

Number of doses of other prescription medications you have given your child since their last exam: _____
 For what? _____

Number of doses of over the counter medications you have given your child since their last exam: _____
 For what? _____

Child's Diet / Mom's Diet if Breastfeeding – please only indicate changes (more or less of item)

	<u>Daily/High</u>	<u>Weekly/Moderate</u>	<u>Monthly or less/Low</u>	<u>None/Never</u>
Dairy	_____	_____	_____	_____
Meat	_____	_____	_____	_____
Vegetables	_____	_____	_____	_____
Fruit	_____	_____	_____	_____
Soy	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Soda/Energy Drinks	_____	_____	_____	_____
Fast food	_____	_____	_____	_____
Candy	_____	_____	_____	_____
Water	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____

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 _____

Current Sports Involvement

Is your child currently involved in any of the following?

- Soccer Football Gymnastics Baseball Basketball Cheerleading
 Martial Arts Ballet Dance/ Tap Hockey (ice field) Tennis
 Swimming Biking Track/ Running Lacrosse Marching Band/ Colorguard
 Golf Wrestling Volleyball Other: _____

Current Health Concerns

List any previous health concerns that have *improved or resolved since starting chiropractic care*:

List continued or new health concerns, *starting with the most important to you*?

Please answer the following questions about the chief concern. (_____)

When did this situation or concern first begin? _____

Is this related to an ___ auto accident ___ injury on the job ___ other injury (_____)

Have you done anything for or gotten any advice or treatment for this issue outside of this office since starting care? Yes No

Explain: _____

Result: _____

What activities aggravate their condition/pain? _____

What activities alleviate their condition/pain? _____

Is the condition worse during certain times of the day? Y N If yes, when? _____

Does it affect their ___ school / ___ exercise or play / ___ attitude, mood / ___ sleep / ___ day-to-day activities

If your child can describe what's occurring, please answer the following:

Do they have ___ pain ___ numbness ___ tingling ___ aches

Is the pain ___ sharp ___ dull ___ throbbing ___ constant ___ intermittent

Do they feel ___ swelling ___ cramping ___ stiffness ___ burning

On a scale of 1-10 (1 least, 10 most), please circle the severity of their symptoms (ask them): 1 2 3 4 5 6 7 8 9 10

I am here to serve you, and encourage you to ask questions.
Your participation is vital and will help determine results.

Remember, positive thinking is as important as your actions.
A thistle seed can only produce a thistle, but
a lotus seed will create a lotus flower!

Parent/ Guardian Name: _____

Signature: _____ Date: _____