GONSTEAD FAMILY CHIROPRACTIC

Child New Patient Intake

Thank you for the opportunity to serve your child. If you have any questions, do not hesitate to ask. We will be happy to help.

PATIENT INFORMATION

Child's Name: _____ **Date:** _____/_____/_____
First MI Last

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Phone: _____ **Secondary Phone:** _____

Birth Date: _____/_____/_____ **Height:**_____ **Weight:**_____ **Age:** _____ **Sex:** ☐Female ☐Male

Parent/Guardian Name: _____ **e-mail address:** _____

Names and Ages of Siblings: _____

Who may we thank for referring you to us? _____

Person to contact in case of an emergency: _____ **Phone:** _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Gonstead Family Chiropractic can address for your child? (please check the purpose for your child's visit)

☐Crisis Management ☐Early detection of problems ☐Prevention ☐Wellness ☐Maximizing brain growth & development
☐Other _____

Date of onset: _____ **Onset was:** ☐Sudden ☐Gradual ☐Associated with an event

Are these concerns affecting your child's quality of life? (Please circle all that apply)

Play:	Y	N	Crawling:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Speech:	Y	N

Duration of problem (episode): _____ **How often is symptom noticeable?** ☐Constantly ☐Frequently ☐Occasionally

Does anything alleviate the symptoms?_____ **Is the condition getting worse?** ☐Yes ☐No

Has your child seen any other health care providers for this condition? ☐Yes ☐No

If yes, whom? When? _____

Please mark below anything your child may have had or is currently experiencing:
Many parents bring their children to our practice to enhance their wellbeing. If your child has no symptoms or complaints and you are here for wellness, please turn to page 2.

Low Back Pain ☐Currently ☐In Past	**Neck Pain** ☐Currently ☐In Past	**Digestive Troubles** ☐Currently ☐In Past	**Asthma** ☐Currently ☐In Past	**Headaches** ☐Currently ☐In Past	**Allergies** ☐Currently ☐In Past
Sleeping Disorders ☐Currently ☐In Past	**Cold/Flu** ☐Currently ☐In Past	**Ear/Throat Infection** ☐Currently ☐In Past	**Breathing Problems** ☐Currently ☐In Past	**Fatigue** ☐Currently ☐In Past	**Irritability** ☐Currently ☐In Past
Hyperactivity ☐Currently ☐In Past	**Bloody Nose** ☐Currently ☐In Past	**Meningitis** ☐Currently ☐In Past	**Diarrhea** ☐Currently ☐In Past	**Constipation** ☐Currently ☐In Past	**Bed Wetting** ☐Currently ☐In Past
Rashes ☐Currently ☐In Past	**Dairy Allergies** ☐Currently ☐In Past	**Sinus Problems** ☐Currently ☐In Past	**Loss of Hearing** ☐Currently ☐In Past	**Learning Disorders** ☐Currently ☐In Past	**Other** ☐Currently ☐In Past

Other: (please explain): _____

FAMILY HISTORY

Choose those involving immediate family and add identification: M=Mother; F=Father; S=Sibling; G=Grandparent

☐Cancer, type:_____ ☐M ☐F ☐S ☐G	☐Depression ☐M ☐F ☐S ☐G	☐Diabetes ☐M ☐F ☐S ☐G	☐Back Problems ☐M ☐F ☐S ☐G
☐Heart Disease ☐M ☐F ☐S ☐G	☐Liver Disease ☐M ☐F ☐S ☐G	☐High Blood Pressure ☐M ☐F ☐S ☐G	☐Neck Problems ☐M ☐F ☐S ☐G
☐Lung Problems ☐M ☐F ☐S ☐G	☐Scoliosis ☐M ☐F ☐S ☐G	☐High Cholesterol ☐M ☐F ☐S ☐G	☐Osteoporosis ☐M ☐F ☐S ☐G
☐Seizures ☐M ☐F ☐S ☐G	☐Osteoarthritis ☐M ☐F ☐S ☐G	☐Rheumatoid Arthritis ☐M ☐F ☐S ☐G	☐Attention Problems ☐M ☐F ☐S ☐G

Other:_____

Health, Wellness & Chiropratic Care

The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM. Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION and results in nerve malfunction .
Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.
The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses you have been subjected to, how they may relate to spinal, nerve and health status and whether they have caused **Vertebral Subluxations**.

HISTORY OF PREGNANCY

During pregnancy, did mom:
Smoke? ☐Yes ☐No **Drink alcohol?** ☐Yes ☐No
Take vitamins/supplements? ☐Yes ☐No. if yes, what? _____
Become ill? (e.g. flu, gastro, pre-eclampsia) ☐Yes ☐No. If yes, What? _____
Take prescription medications? ☐Yes ☐No. If yes, what? _____
Receive ultrasounds? ☐Yes ☐No. If yes, how many? _____
Undergo investigations? (e.g. amniocentesis, CVS) ☐Yes ☐No. If yes, what? _____
Were there any complications to the pregnancy? ☐Yes ☐No. If yes, what? _____
Mother's obstetrician/midwife/family physician was: _____
Was mom on any medications? (prescription, over-the-counter, recreational) ☐Yes ☐No
if yes, explain: _____

HISTORY OF BIRTH

Where was your child born? ☐Hospital ☐Birthing Center ☐Home ☐Midwife Birth
Duration of Gestation: _____ weeks **Duration of labor:** _____ **Duration of pushing stage:** _____
Birth Weight: _____ **Birth Length:** _____ **APGAR at birth:** _____/10 **APGAR at 5 minutes:** _____/10
Was the birth assisted? ☐Yes ☐No if yes, what: ☐forceps ☐vacuum ☐c-section ☐induced labor
Complications at birth: ☐Fetal Distress ☐Meconium ☐Head Presentation ☐Face Presentation ☐Breech
Was oxytocin/Pitocin used? ☐Yes ☐No **Was an epidural administered?** ☐Yes ☐No
Were any medications given to your baby at birth? (e.g. antibiotics/vaccines) ☐Yes ☐No
Did your child spend any time in intensive care (NICU)? ☐Yes ☐No. If yes, how long? _____

GROWTH & DEVELOPMENT

Do you feel your child is developing as they should compared to other kids of the same age? ☐Yes ☐No
Was the infant alert and responsive within twelve hours of delivery? ☐Yes ☐No
If No, Explain: _____
At what age did the child: Hold head up:_____ Sit alone: _____ Crawl:_____ Walk:_____
Patient hospitalization/surgical history: (please list below all surgeries and hospitalizations, including the year)
_____
_____
How would you rate his/her quality of sleep? ☐Excellent ☐Good ☐Fair ☐Poor
Do your child's sleeping patterns seem normal to you: ☐Yes ☐No, hours a night _____.
What position does your child sleep in? ☐Back ☐Side ☐Stomach/Chest
Rate your child's Posture: Poor 1 2 3 4 5 6 7 8 9 10 Excellent
Has your child fallen from a height of 3ft or above? ☐Yes ☐No explain: _____
Has your child experienced a loss or emotional trauma? ☐Yes ☐No explain: _____
How many hours a day does your child watch TV: _____ **Play on computer/iPad**: _____
Has you child been in any car accidents: ☐Yes ☐No explain: _____
Does your child's siblings have any health concerns? ☐Yes ☐No. If yes, please describe: _____
_____
Who is your family's primary care physician? _____
Do any of your relatives or friends see a chiropractor? ☐Yes ☐No
If yes, do they use chiropractic for ☐Health maintenance/optimization ☐Health problems ☐Both
Are you seeking chiropractic for ☐Health maintenance/optimization ☐Health problems ☐Both

Health, Wellness & Chiropratic Care

EMOTIONAL STRESS

Was the mother stressed during the pregnancy? ☐Yes ☐No. Comment (if required):_____
Any difficulties with breastfeeding with mom or child? ☐Yes ☐No
Any difficulties with bonding between child and mom? ☐Yes ☐No
Does your child have any behavioral issues? ☐Yes ☐No. If yes, what:_____
Does your child have difficulty sleeping (e.g. nightmares, sleepwalking, insomnia)? ☐Yes ☐No
If yes, please explain:_____
Does your child attend day care? ☐Yes ☐No. If yes, from what age? _____
Is your child nervous or has anyone suggested your child is nervous? ☐Yes ☐No
Do you feel your child's emotional development is normal for their age? ☐Yes ☐No
Rate your child's level of stress (brought on by moving school, divorce, death, etc.):
LOW 1 2 3 4 5 6 7 8 9 10 HIGH

CHEMCIAL STRESS

Was (is) the child breast-fed? ☐Yes, for how long? _____ ☐No, explain reason _____
Formula introduced at age: _____ **Brand of formula used:** _____
Cow's milk introduced at age: _____ **Began solid food at age:** _____
Food/Juice intolerance: ☐Yes ☐No if yes, type: _____
What does your child like to eat/favorite food(s)? _____
What does your child regularly drink? _____
How often does your child receive: processed foods, white sugar, gluten & dairy in their diets?
☐Never ☐On special occasions ☐On weekends ☐A few times per week ☐Daily ☐Almost every meal
Are you aware of the impact of food/nutrition on your child's behavior? ☐Yes ☐No
Rate your child's diet: ☐Excellent ☐Good ☐Poor
Has your child received vaccinations: ☐Yes ☐No If yes, which ones: _____
Did you notice any changes in your child after their vaccinations? ☐Yes ☐No. If yes, what? ☐Fever
☐Irritability ☐Lethargy/Fatigue ☐Arching ☐Drowsiness ☐Bowel troubles ☐Feeding issues ☐Other: _____
Has your child received antibiotics: ☐Yes ☐No, Total courses of antibiotics to date: _____
Current medications and reasons: _____ ☐None
Pets or smokers at home? ☐Smoker ☐Dog ☐Cat ☐Bird ☐Reptile ☐Fish tank ☐Other:_____

PHYSICAL STRESS

Where there any traumas to the mother during the pregnancy (e.g. falls, accidents)? ☐Yes ☐No
If yes, please explain:_____
Research suggests that over 60% of children fall from an elevated height in the first 12 months of life. Has your child had any falls since birth? (e.g. from table, off couch, out of bed, etc.) ☐Yes ☐No.
If yes, please explain:_____
Any traumas resulting in bruises, cuts, stitches or fractures? ☐Yes ☐No. If yes, what?_____
_____
Has your child ever been involved in a motor vehicle accident? ☐Yes ☐No
Does your child play sports/exercise regularly? ☐Yes ☐No **Average hours spent at play a day:** _____hours
Do you feel your child struggles to carry/wear their backpack? ☐Yes ☐No **Weight of full backpack:** ____lbs
If you could improve one aspect of your child's health or behavior, what would it be: _____
_____

Parent/Guardian Signature: _____ **Date:** _____/_____/_____

There are always risks associated with any therapeutic intervention! Regarding manual spinal adjustment, the risk of permanent injury or death is approximately 1 in 5,600,000. To place this in perspective, the risk of death from gastric bleeding when taking an aspirin for aches and pains is approximately 3 in 1000. Statistically there is a greater chance of being hit by lightening than experiencing permanent damage or dying form a manual adjustment.