

# Welcome to Dynamic Family Chiropractic

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## Infant / Child Health History Form

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

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

Parents Name \_\_\_\_\_ Home ( ) \_\_\_\_\_ S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Male \_\_\_ Female \_\_\_ Number of Children \_\_\_\_\_ Who may we thank for referring you to our office? \_\_\_\_\_

Reason for consulting our office? \_\_\_\_\_

If your child has no symptoms or complaints, and is here for wellness services, please check \_\_\_; others need to briefly describe the chief area of complaints, including the effects it has on the child.

If he/she is experiencing pain, is it: Sharp \_\_\_ Dull \_\_\_ Comes and Goes \_\_\_ Travels \_\_\_ Constant \_\_\_

Since the problem started, is it: About the same \_\_\_ Getting Better \_\_\_ Getting Worse \_\_\_

Other doctors seen for this problem:

Chiropractor: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_

Other: \_\_\_\_\_

List Medications the child is taking or surgeries the child has had:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most of the time the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.

### Pregnancy:

Were there any complications to the pregnancy? \_\_\_\_\_

Was mom on any medications, prescription or over-the-counter? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Did Mom or Dad smoke during pregnancy? Yes \_\_\_ No \_\_\_ Who? \_\_\_\_\_

Was baby ever in the Breech position? Yes \_\_\_ No \_\_\_

How many ultrasounds were performed? \_\_\_\_\_

### Birth and Delivery:

Where was baby born? Home \_\_\_ Hospital \_\_\_ Birthing Center \_\_\_ Other: \_\_\_\_\_

Was the delivery: Vaginal \_\_\_ C-Section \_\_\_ Were any devices used? Forceps \_\_\_ Vacuum \_\_\_

How long was the labor? \_\_\_\_\_ How long was the delivery? \_\_\_\_\_

Was oxytocin/pitocin used? Yes \_\_\_ No \_\_\_ Was an epidural administered? Yes \_\_\_ No \_\_\_

### Infancy:

Was infant vaccinated? Yes \_\_\_ No \_\_\_

Was there any prolonged use of medicines or an inhaler? Yes \_\_\_ No \_\_\_ If yes, which \_\_\_\_\_

Did the infant suffer any traumas such as a serious falls or car accidents? Yes \_\_\_ No \_\_\_

Has the infant been under regular chiropractic care? Yes \_\_\_ No \_\_\_

### Childhood Years:

Did the child have any childhood illnesses? Yes \_\_\_ No \_\_\_

Has the child had any surgeries? Yes \_\_\_ No \_\_\_

Has the child been involved in any car accidents? Yes \_\_\_ No \_\_\_

Does the child play in any youth sports? Yes \_\_\_ No \_\_\_

## HISTORY OF PRESENT COMPLAINT

Complaint: \_\_\_\_\_

Qual & Chara: \_\_\_\_\_

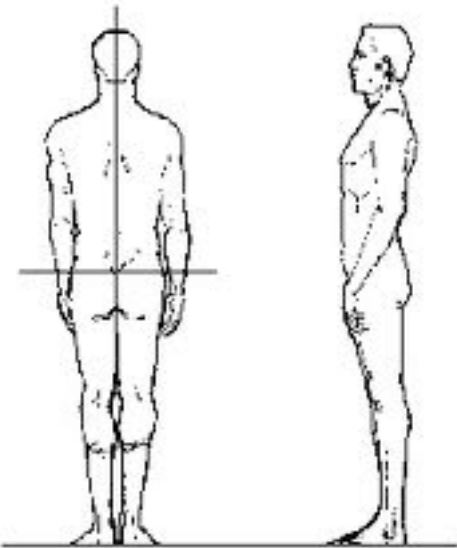
On, Dur, Intens, Freq, Loc, Rad: \_\_\_\_\_

Better or worse: \_\_\_\_\_

Prior TX, meds, other: \_\_\_\_\_

## EXAMINATION

### Asymmetry



### General Observations

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#### Reflexes

Webster's Coronal Suture:	R	L
Rooting Reflex:	R	L
Sucking Reflex:	R	L
TMJ:	R	L
Upper Palate:	R	L
Acoustic Blink:	R	L
Visual Blink:	R	L
Neck Righting:	R	L
ATNR:	R	L
Ortolani:	R	L
Moro:	P	A
Parachite:	P	A
Placing:	P	A

#### Palpation

C0	T1	L1
C1	T2	L2
C2	T3	L3
C3	T4	L4
C4	T5	L5
C5	T6	
C6	T7	S1
C7	T8	S2
	T9	S3
	T10	S4
	T11	S5
	T12	

Diagnosis: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## DFC Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

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

**Health:** A 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 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore begin my chiropractic examination and any other further care on this basis.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

### **Consent to evaluate and adjust a minor child:**

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

I have read and understand the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date