Infant / Child Health History Form
(Age 10 & Under)

Dynamic Family Chiropractic
Wellness Center

First Name_____ MI____ Last_____ Birth Date___/___/___ Age_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Male _____ Female_____ Number of Siblings_____ Parents Name_____

Home ( )_____ Cell ( )_____ Email_____

Can we send you occasional text messages for important reminders? Yes_____ No_____

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:_____

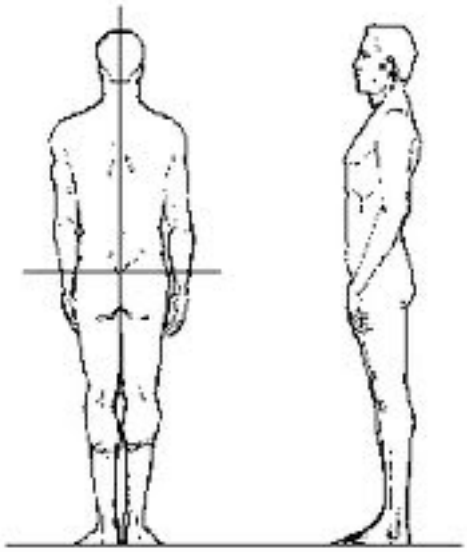
_____

Prior TX, meds, other:_____

_____

EXAMINATION

Asymmetry



General Observations

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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:_____

Dynamic Family Chiropractic 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