CHILD HEALTH PROFILE & PERMISSION – Completed by Parent

Initial Visit Date: _____/_____/_____

Name of Parent: _____Name of Child:_____
Address:_____ City:_____State:_____ Zip:_____
Home #:_____ Work #:_____ Cell #:_____
Date of Child's Birth: _____/_____/_____ Child's Age: _____ Child's Gender: Male / Female
How did you hear about our office?_____

Has your child ever received Spinal Adjustments or Network Spinal Analysis Entrainments by a Doctor of Chiropractic before? YES NO If yes, when and by whom? _____
Total time receiving care?_____

Have you or your spouse ever received Chiropractic care? YES NO Network Care? YES NO

What other natural forms of healthcare has your child received?_____

What do you hope for your child to receive from Chiropractic care in this office?_____

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR CHILD'S HEALTH HISTORY

Were you physically ill prior to or during the pregnancy? YES NO _____

Was the pregnancy difficult? YES NO _____

Did you have any falls, accidents or physical injuries during the pregnancy? YES NO _____

Was your labor chemically induced? YES NO _____

Were you conscious/semiconscious/unconscious? _____

Was the birth: ❑drug induced ❑forceps or suction ❑C-section ❑breech
❑natural ❑prolonged ❑cord around the neck
Was the birth: ❑at home ❑in a birthing center ❑in a hospital ❑other

Was your child incubated or isolated? YES NO _____

Was your child: ❑bottle fed ❑breast fed ❑other

Has your child even been unconscious? YES NO_____

Has your child ever used crutches or corrective braces? YES NO_____

Is your child accident-prone? YES NO_____

Has your child had any falls down steps? YES NO_____

Has your child ever been involved in an auto accident? YES NO_____

Has your child ever been hospitalized or had surgery? YES NO_____

Has your child ever had any broken bones or sprain injuries? YES NO_____

Is your child currently on any medications/ YES NO In the past? YES NO_____

Please list medications:_____

Has your child been vaccinated? YES NO_____

Is your child active in any particular sports? YES NO If yes, which ones?_____

Is your child hyperactive? YES NO_____

Does your child have learning disorders? YES NO_____

Does your child have poor posture? YES NO_____

Is your child nervous, or has anyone suggested that your child was nervous? YES NO_____

Has your child experienced any of the following?
(if so, please list when and any further comments you wish to share):

❑Headaches ❑Allergies ❑Ear infections ❑Breathing problems ❑Fatigue
❑Irritability ❑Hyperactivity ❑Flu ❑Frequent colds ❑Bloody nose
❑Meningitis ❑Diarrhea ❑Colic ❑Digestive problems ❑Rashes
❑Bed wetting ❑Asthma ❑ADD/ADHD ❑Sleeping problems ❑Constipation
❑Hay fever ❑Autism ❑Anxiety/stress ❑Asperger's ❑Milk or lactose intolerance
❑Other_____

Which of the above bothers your child the most?_____

How long has your child been bothered by the condition?_____

Does this problem effect your child's ability to enjoy school/play?_____

Does this problem effect your child's ability to enjoy family and friends?_____

Does this problem effect your child's ability to sleep?_____

How would you rate your child's physical health?
❑Excellent ❑Good ❑Fair ❑Poor ❑Getting better ❑Getting worse

How would you rate your child's emotional/mental health?
❑Excellent ❑Good ❑Fair ❑Poor ❑Getting better ❑Getting worse

Is there anything else that you wish to share which may help us to better understand your child?_____

_____

_____

I hereby authorize Dr. Karen Lumb, DC, of Vitality Wellness Center, and whomever she may designate, to administer care necessary to my child named above.

Parent/Guardian's Name:_____ Date:_____

Parent/Guardian's Signature: _____ Witness:_____