

Welcome!

Name _____ Age _____
Birthday _____ Address _____
City _____ State _____ Zip Code _____
Name(s) and age(s) of siblings _____
Parent(s)/Guardian (s) Name(s) _____
Parent(s)/Guardian(s) occupation(s) _____
Parent (s)/Guardian (s) Phone (Home) _____ (Work/Cell) _____

Who may we thank for referring you and your child to **Women's Wellness Comprehensive Care**? _____
Is your child currently benefiting from chiropractic care? Yes No
When was their last visit? _____
Name of your family chiropractor _____
What would you like your child to receive from care in this office? _____

Have you consulted any other health care practitioners for this reason? _____
If Yes, Who?: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.
Parent/Guardian Signature _____ **Date** _____

Many of the health challenges that people will face originate from stressors experienced during developmental years (including gestation and birth). These stressors (traumas) may be emotional, physical, or chemical. **This health record is designed to help us understand the stressors your child might have already experienced, and to maximize your child's health and wellness.**

The Pregnancy Process

During the pregnancy process, did the mom:
 Take medications? Type _____
 Smoke or consume alcohol or drugs? _____
 Experience any illness? Type _____
 Undergo a lot of stress? _____
 Receive ultrasounds or other radiation? _____ How many? _____

The Birthing Process

Birthplace: Home Hospital Birthing Center
Type of Birth: Vaginal C-Section Cephalic (head first)
 Breech (feet first) Occiput Posterior (facing forward)

Procedures: Forceps Vacuum Extraction

Birth Assistants: M.D. Midwife Doula

Did the person assisting the delivery twist or pull the baby during the delivery?

Yes No

How long did labor & delivery last? _____ hours

What was the mother's position during labor? Back Side

Sitting Standing Other _____

Did the mother have an episiotomy? Yes No

Was labor chemically induced? Yes No

What was the child's gestational age at birth? _____

Was your child breast-fed soon after the birth? Yes No

Were any drugs administered during the labor process (IV, epidural)?

Yes No

Was your child subjected to any of the following? Silver Nitrate eye drops

Incubation (how long?) _____ Vitamin K injection

Hepatitis injection Separation from mother (how long?) _____

Vaccinations

Have you chosen to vaccinate your child? Yes No

If yes, check all vaccinations received: DPT MMR Polio

Chicken Pox Hepatitis Flu Other _____

Describe any reactions to the vaccine(s): _____

Growth and Development

At what age did your child....?

Follow an object _____ Respond to sound _____
Hold up head _____ Vocalize _____
Sit unassisted _____ Teethe _____
Crawl _____ Walk _____

Has your child's body communicated any of the following?

- | | | |
|---|--|---------------------------------------|
| <input type="radio"/> vision problems | <input type="radio"/> pink eye | <input type="radio"/> constipation |
| <input type="radio"/> headaches | <input type="radio"/> ear problems | <input type="radio"/> asthma |
| <input type="radio"/> sleeping difficulty | <input type="radio"/> tubes in the ears | <input type="radio"/> colic |
| <input type="radio"/> irritability | <input type="radio"/> attention problems | <input type="radio"/> hyperactivity |
| <input type="radio"/> skin problems | <input type="radio"/> frequent colds | <input type="radio"/> bedwetting |
| <input type="radio"/> breathing problems | <input type="radio"/> digestive problems | <input type="radio"/> allergies _____ |

other _____

Is your child accident-prone? _____

Average number of hours your child watches television, plays on the computer, or plays electronic games each week, if any? _____

Do you feel that your child's social and emotional development is normal for their age? (Please explain) _____

Any night terrors, sleep walking, difficulty sleeping? _____

Has your child:

Been hospitalized/surgery? No Yes: _____

Had a severe fall? No Yes: _____

Been in a car accident? No Yes: _____

Any child traumas resulting in bruises, fractures, or stitches? _____

Any sports participation and age began? (list sports and number of hours/wk)

Approximate hours of playtime each week _____

Is a school backpack used? (Heavy or Light) _____

Has your child ever taken antibiotics? Yes No

If yes, how often & why?: _____

Has your child ever taken or currently taking any other medications (OTC or prescription)? No Yes If yes, explain: _____

Does your child consume?

- fruits (organic is best) vegetables (organic is best) lean meats and fish
 nuts omega 3 fatty acid supplement probiotics
 caffeine soda sugar artificial sweetener fast food
 processed foods tap water/unfiltered water/plastic bottled water

What changes in your child's health or behavior would you like to see? _____

Is now a good time to commit to cultivating these changes? _____

Who is on your child's health care team (massage, nutrition, acupuncture, etc.?) _____

Chiropractors Notes:

(please leave blank)



Top 5 Health Goals

If your child is old enough, please work with them to establish their top 5 health goals and action steps. (morning exercise, eating healthy, creative expression, etc)

My Action Steps

Understanding Our Service

When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective.

In this office, chiropractic adjustments are delivered to free up Life Force, allowing every individual whether a newborn, an athlete or a grandparent to express more health. **Health** is defined as the state of optimal physical, mental and social well being, not merely the absence of disease or infirmity. **Adjustments** are specific applications of forces delivered to facilitate the body's correction of subluxations. **Subluxations** are patterns of tension stored in the body causing an alteration of nerve function and interference to the transmission of mental impulses (Life Force), the essential impulses that allow the expression of health, vitality and personal expression.

Specific chiropractic adjustments deepen everyone's potential to heal biologically and at the core. In some, physical, emotional, and chemical challenges may clear up quickly, in others the process is slower and in some it appears partial or not at all. Yet everyone will benefit from a properly functioning nerve system and greater life expression. Healing is a non-linear path, which means that one might experience ups and downs during a course of chiropractic care. This might include the experience of emotions, soreness, fatigue and sensation awareness as subluxations are released and the body finds a new alignment. It also might mean greater energy, rest, ease, creativity and connectivity.

Chiropractic is not a substitute, an alternative or a preventative form of medicine. Chiropractic specializes in the expression of life, wellness, healing and well being, whereas, medicine specializes in the diagnosis and treatment of symptoms, sickness and disease. It is not Dr. Stacey Cantrell's and/or Dr. Christine Maguire's goal or intention to diagnose, treat or attempt to cure any physical, mental, or emotional ailments. The only diagnosis made in this office is that of subluxations. However, if during the course of chiropractic care, non-chiropractic or unusual findings are encountered, these will be brought to your attention. If you desire diagnosis or treatment for these findings, the chiropractor will recommend that you seek the services of another health care provider.

I, _____, the undersigned, have completely read and understood the above statements and choose to be served by Dr. Stacey Cantrell and/or Dr. Christine Maguire with this understanding for myself. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

Signature _____ Date _____

Signature of Parent or Guardian (for anyone under the age of 18)

_____ Date _____