



**BRIGHTLIFE**  
CHIROPRACTIC

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**Pediatrics**  
Infants - School Aged



Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's/Guardians' Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ May we leave a message?  Yes  No

Parent's Cell Phone: \_\_\_\_\_ May we leave a message?  Yes  No

Parent's Work Phone: \_\_\_\_\_ May we leave a message?  Yes  No

Parent's Email: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Height (of child): \_\_\_\_\_ Weight: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Siblings and ages: \_\_\_\_\_

Previous Chiropractic Care?  Yes  No

**Emergency Contact**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone number: \_\_\_\_\_ Alternative phone number: \_\_\_\_\_

**Family Doctor**

Name: \_\_\_\_\_ Professional Designation: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Date and reason of last visit: \_\_\_\_\_

May we communicate with your family doctor regarding your child's care if necessary?  Yes  No

**Other Health Care Professionals**

(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, OT, Massage Therapist, etc)

Name: \_\_\_\_\_ Professional Designation: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Date and reason of last visit: \_\_\_\_\_

Name: \_\_\_\_\_ Professional Designation: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Date and reason of last visit: \_\_\_\_\_

**Why have you decided to have your child evaluated by a Chiropractor?**

- He/She is continuing care from another chiropractor.
- I recently had my spine checked and understand the value in getting my child checked.
- I have concerns about his/her health and I'm looking for answers.
- He/She has a specific condition and I've learned that chiropractic may be able to help.
- I want to improve my child's immune function.

**Wellness Profile**

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called *vertebrae*. Many of the common health challenges that adults experience have their origins during the *developmental years*, some starting at birth. Layers of damage to the spine and *nervous system* occur as a result of various *traumas, toxins, and emotional stress*. The result may be misalignment to the spinal column and damage to the nervous system - a condition called *Vertebral Subluxation*. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's ability to heal.

**What signals has your child's body been communicating?**

<p><b>CURRENT</b> <b>PREVIOUS</b></p>	<p><b>CURRENT</b> <b>PREVIOUS</b></p>	<p><b>CURRENT</b> <b>PREVIOUS</b></p>
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> <input type="checkbox"/> Failure to Thrive / Slow Weight Gain
<input type="checkbox"/> <input type="checkbox"/> Respiratory Tract Infections	<input type="checkbox"/> <input type="checkbox"/> Constipation	<input type="checkbox"/> <input type="checkbox"/> Slow or Absent Reflexes
<input type="checkbox"/> <input type="checkbox"/> Sinus Problems	<input type="checkbox"/> <input type="checkbox"/> Flatulence	<input type="checkbox"/> <input type="checkbox"/> Asymmetrical Crawling or Gait
<input type="checkbox"/> <input type="checkbox"/> Ear Infections	<input type="checkbox"/> <input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> <input type="checkbox"/> Weight Challenges
<input type="checkbox"/> <input type="checkbox"/> Tonsillitis	<input type="checkbox"/> <input type="checkbox"/> Neck Pain	<input type="checkbox"/> <input type="checkbox"/> Bed Wetting
<input type="checkbox"/> <input type="checkbox"/> Strep Throat	<input type="checkbox"/> <input type="checkbox"/> Torticollis / Head Tilt	<input type="checkbox"/> <input type="checkbox"/> Sleep Problems
<input type="checkbox"/> <input type="checkbox"/> Frequent Colds / Croup	<input type="checkbox"/> <input type="checkbox"/> Trouble Feeding on One Side	<input type="checkbox"/> <input type="checkbox"/> Night Terrors
<input type="checkbox"/> <input type="checkbox"/> Recurrent Fevers	<input type="checkbox"/> <input type="checkbox"/> Back Pain	<input type="checkbox"/> <input type="checkbox"/> Tip Toe Walking
<input type="checkbox"/> <input type="checkbox"/> Eczema	<input type="checkbox"/> <input type="checkbox"/> Growing Pains	<input type="checkbox"/> <input type="checkbox"/> Sensory Processing Issues
<input type="checkbox"/> <input type="checkbox"/> Rashes	<input type="checkbox"/> <input type="checkbox"/> Scoliosis	<input type="checkbox"/> <input type="checkbox"/> Seizures
<input type="checkbox"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> Red. Swollen, Painful Joint	<input type="checkbox"/> <input type="checkbox"/> Tremors / Shaking
<input type="checkbox"/> <input type="checkbox"/> Food Sensitivities	<input type="checkbox"/> <input type="checkbox"/> Colic	<input type="checkbox"/> <input type="checkbox"/> ADD / ADHD
<input type="checkbox"/> <input type="checkbox"/> Digestive Problems	<input type="checkbox"/> <input type="checkbox"/> Frequent Crying Spells	<input type="checkbox"/> <input type="checkbox"/> Autism / PPD

Do you have a specific concern that brings you in?

No, I would like my child's nervous system assessed to achieve optimal health & functioning.  
 Yes: \_\_\_\_\_

*If yes, please answer the following questions:*

Does your child appear to be in pain or discomfort? \_\_\_\_\_ For how long? \_\_\_\_\_

Is it getting better, worse, or staying the same? \_\_\_\_\_ Suddenly or gradually? \_\_\_\_\_

Have you seen other health professionals regarding this complaint?

No  if Yes, Whom? \_\_\_\_\_

What treatment did they use? \_\_\_\_\_

Has your child taken any medication for this complaint?  No  Yes:

Has your child ever experienced this complaint before?  No  Yes:

Has your child received any treatment at this time?  No  Yes:

Has your child had x-rays in relation to the current complaint?  No  Yes:

Has your child had any blood work done for the current complaint?  No  Yes:

### Birth Experience

- Location of Birth:  Home  Hospital  Birthing Center  Other: \_\_\_\_\_
- Birth Attendants:  Doula  Midwife  GP  OB  Other: \_\_\_\_\_
- Medications during labor/delivery including IV antibiotics):  No  Yes: \_\_\_\_\_
- Was Pitocin used to induce / speed up labor?  No  Yes
- Were your membranes ruptured by a medical professional?  No  Yes
- Was your child at anytime during pregnancy in a constrained position?  No  Yes  Unsure  
If yes, please describe:  Breech  Transverse  Face / Brow presentation
- Was your delivery vaginal or C-section? \_\_\_\_\_ If C-section, was it planned or emergency? \_\_\_\_\_
- If it was vaginal, was the baby presented:  Head  Face  Breech
- Were any of the following interventions used?  Forceps  Vacuum Extraction  Other
- Were there any complications during delivery?  No  Yes  
If yes, please specify: \_\_\_\_\_
- How long was the labor from the first regular contractions to the birth? \_\_\_\_\_ hours.
- How long was the second stage (the pushing phase) of the labor? \_\_\_\_\_ hours.
- Was the baby born with any purple markings / bruising on their face or head?  No  Yes
- Any concerns about misshapen head at birth?  No  Yes

### Post Natal & Infant History

- How many weeks gestation was the baby at birth? \_\_\_\_\_ Weight: \_\_\_\_\_ Length: \_\_\_\_\_
- If known, APGAR scores as: 1 minute: \_\_\_\_\_/10 5 minutes: \_\_\_\_\_/10
- Was the baby ever admitted to the NICU?  No  Yes  
If yes, for how long and why? \_\_\_\_\_
- Was any medication given to the child at birth?  No  Yes  Unsure  
If yes, what medication and why? \_\_\_\_\_
- Was your child exclusively breastfed?  No  Yes  Months: \_\_\_\_\_
- Was your child breastfed + formula fed?  No  Yes  Months: \_\_\_\_\_
- Did your child show any sensitivities to formula (reflux, eczema, arching back)?  No  Yes
- What age did you introduce solid foods to your child? \_\_\_\_\_ months
- Did you introduce cereal or grains within your child's first year?  No  Yes
- Did your child spend a lot of time in any baby devices (bouncy seats, swings, bumbos, car seats, etc?)  
 No  Yes Which ones? \_\_\_\_\_

**Physical Traumas**

Has your child ever fallen from any high places?  No  Yes \_\_\_\_\_

Has your child ever been involved in a motor vehicle accident?  No  Yes \_\_\_\_\_

Has your child broken any bones?  No  Yes \_\_\_\_\_

Has your child had any previous hospitalizations?  No  Yes \_\_\_\_\_

Has your child had any previous surgeries?  No  Yes \_\_\_\_\_

Does your child use a tablet, computer, or video game?  Never  Rarely  Daily  Several hrs/day

Does your child watch TV?  Never  Rarely  Daily  Several hrs/day

Does your child exercise?  No  Daily  Weekly  Seasonally

Does your child play contact sports?  No  Daily  Weekly  Seasonally

Does your child sleep on their...  Back  Belly  Sides (both, right, left)

Does your child carry a back pack?  No  Yes

Does it weigh less than 15% of their body weight?  No  Yes

Do they wear their back pack on 2 shoulders?  No  Yes

Do your child's shoes show excessive or uneven wearing out?  No  Yes

Does your child wear custom orthotics?  
 No  Yes, For what purpose? \_\_\_\_\_

**Goals & Consent**

Do you feel your child developmentally appropriate for their age?

Intellectually:  Yes  No \_\_\_\_\_

Emotionally:  Yes  No \_\_\_\_\_

Physically:  Yes  No \_\_\_\_\_

What is your primary goal for your child at our clinic? \_\_\_\_\_

Our goals are to provide a detailed assessment of your child's current status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You've taken an important step for your child's future through a chiropractic evaluation!

**Consent to Evaluation of a Minor Child**

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_  
(print name of consenting adult) (print name of minor)

hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, and physical examination. Any findings will be communicated before consenting to commencement of treatment, if appropriate.

\_\_\_\_\_  
Consenting Adult's Signature Date