

CHILD PROFILE (AGES 1 - 12)

The information you provide is for your child's benefit and protection. It is for the private use of this office (unless you sign a release for legal purposes) to aid your Doctor in gaining a better understanding of your child's condition.

****Please ask for assistance if you do not understand a question****

Full Name: _____ Date: _____

Address: _____

City: _____ Postal Code: _____

Birth Date: _____ Age: _____ Sex: M F

Mother's Name _____ Father's Name: _____

Home Phone: _____ Bus Phone: _____ Cell Phone: _____

Names and ages of siblings (if applicable): _____

Weight: _____ Height: _____ AHC #: _____

Child spends days with: mother father grandparent
sitter daycare kindergarten public school
home school private school other: _____

Who referred you to our clinic? _____

Has your child seen a chiropractor before? Yes No

If yes, who? _____

Name of Medical Doctor: _____

Date of last visit to Medical Doctor: _____

Date of last visit to Pediatrician: _____

Date of last visit to Dentist: _____

Date of last visit to Optometrist/Ophthalmologist: _____

Reason for child's visit: _____

What is your child's dominant hand? Right Left

Any problems for mother and/or child during pregnancy? Yes No

If yes, please describe? _____

Did your child have prior health problems that have been outgrown or corrected? Yes No

If yes, please describe? _____

What is your child's bedtime? _____ Number of hours of sleep? _____

Quality of sleep: good fair poor restless

How old is your child's bed? _____

Does your child awaken frequently with a regular complaint? Yes No

If yes, please describe? _____

Has your family experienced emotional distress such as:

separation divorce loss of a parent loss of a sibling
loss of someone close near fatal disease strong emotional upset
other: _____

Would you describe your child's health as:

very robust very good average poor sickly

How is your child's schooling progressing?

no concerns poorly average doing well

Does your child seem to be developing as you would expect regarding size, strength and coordination? Yes No

Please check any of the following that has affected your child:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Eye Infection | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Throat Infection |
| <input type="checkbox"/> Sinus Infection | <input type="checkbox"/> Thrush | <input type="checkbox"/> Tubes in Ears |
| <input type="checkbox"/> Watery/Swollen Eyes | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Swollen Lymph Nodes | <input type="checkbox"/> Frequent Fevers | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Bloating Abdomen | <input type="checkbox"/> Hernia | <input type="checkbox"/> Appendix |
| <input type="checkbox"/> Baby Measles | <input type="checkbox"/> Undescended Testicles | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Snoring | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Other: _____ | | |

At what age was your child potty trained? _____

Are you concerned with any of the following regarding bowel and bladder function?

regularity stool consistency pain with bowel movements bedwetting

Does your child complain of pain or soreness:

in the legs, knees, ankles or feet? Yes No

in the arms, elbows, wrists or hands? Yes No

Has your child ever been hospitalized? Yes No

If yes, why? _____

Are you concerned about any of the following regarding your child's walking pattern:

limp toe walking scoliosis pain unusual shoe wear foot positioning

other: _____

Any other concerns regarding your child's health: _____

Have any X-Rays been taken of your child's back or neck? Yes No

If yes, when and where? _____

Please check any of the following stresses that has affected your child:

- Slips/Falls
- Car Accidents: when? _____
describe injuries: _____
- Knocked Unconscious: when? _____
how? _____
- Sports Injuries: when? _____
describe injuries: _____
- Poor Posture
- Sleeping (on stomach)
- Excessive Computer Work
- Bone Fracture/Surgery: when? _____
where? _____
- Dislocation: describe: _____
- Major/Spine Trauma: describe: _____
- Second-hand Smoke
- Poor Diet: describe: _____
- Caffeine: Tea/Iced Tea amount/day: _____
Cola amount/day: _____
Chocolate amount/day: _____
- Excessive Sugar
- Environment (ex. Pollution)
- Prescription Drugs - specify: _____
- Over-the-Counter Drugs (ex. Advil, Tylenol): _____

How many glasses of water does your child drink daily? _____

Is your child currently on a program of:

- | | | | |
|-----------|-----|----|--------------------------|
| Vitamins | Yes | No | type & amount/day? _____ |
| Minerals | Yes | No | type & amount/day? _____ |
| Diet | Yes | No | describe: _____ |
| Phys. Ed. | Yes | No | describe: _____ |
| Herbs | Yes | No | type & amount/day: _____ |

Is your child frequently ill? Yes No

Is your child experiencing energy loss or fluctuating energy levels? Yes No

Has there been a recent change in your child's strength? Yes No

Does your child have any allergies? Yes No

If yes, specify: _____

Is your child having allergy shots? Yes No

Is your child following an immunization program? Yes No

Has your child had any reaction to the immunization program? Yes No

If yes, please describe: _____

Does your child have an intolerance to dairy products? Yes No

If no, how many glasses of milk does your child drink daily? _____

Have any blood relatives suffered a stroke? Yes No

If yes, who? _____

Do you have a family history of:

Diabetes Yes No who? _____

Heart Disease Yes No who? _____

Arthritis Yes No who? _____

Cancer Yes No who? _____

Are you worried/nervous about your child receiving chiropractic care? Yes No

Chiropractic Care and Children

Children benefit from chiropractic care for the same problems for which adults are treated, which are predominantly musculo-skeletal disorders. For example, children have a fairly high incidence of back pain and other musculo-skeletal problems caused by participation in sports, sitting in desks at school, computer activities, and the frequent tumbles and falls active children experience.

Chiropractic care is widely recognized as one of the safest, drug-free, surgery-free therapies available for the treatment of spinal pain syndromes. Few other therapies can demonstrate a better safety record. Provincial governments across Canada recognize that the chiropractic profession's scope of practice includes treating patients of all ages.

Are chiropractors trained to treat children? Yes. Chiropractors have seven years of university level education and training including 756 hours of training exclusively in adjustment techniques. Treatment for children is adapted to the age and smaller frame of the child and is delivered in a gentle manner to which children respond well.

What childhood conditions can chiropractors treat? More than 44 studies have been conducted into the effectiveness of chiropractic treatment for neck and back pain alone and there is well-documented evidence of the prevalence of back pain in children. Young children can also benefit from a spinal check-up at key stages in the same way that they benefit from eye examinations and dental check-ups. For example, starting to sit, crawl, and walk are developmental points when a check-up will confirm that the spine is functioning properly or provide an early warning of any potential problems.

Chiropractors also consistently see evidence that spinal adjustment of infants and children has many positive effects for a variety of conditions, however; well-controlled research studies are required to better understand some of the benefits that are commonly seen in practice. As research unfolds, studies are confirming these benefits. For example, in recent years there have been two important studies investigating the effectiveness of chiropractic care for treating childhood colic and asthma.