

PARENT/CHILD COMPREHENSIVE HEALTH PROFILE

Name of Parent: _____ Name of Child: _____

Address: _____

City/State/Zip: _____

Phone# Work: _____ Home: _____

Date of Birth: ____/____/____ Age: ____ Sex: M F

How did you hear about our office? _____

Has your child ever received spinal adjustments by a Chiropractor before? Y N

If yes when and by whom? _____ How long did your child go? ____

Have you or your spouse ever received chiropractic care? Y N

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 HISTORY

Were you physically ill prior to or during the pregnancy? Y N

Was the pregnancy difficult? Y N

Did you have any falls, accidents, or physical injuries during the pregnancy? Y N

Was your labor chemically induced? Y N

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? Y N

Was your child: _bottle fed _breast fed _other

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 noses _Meningitis _Diarrhea _Colic
_Constipation _Rashes _Milk or lactose intolerance _Bed Wetting _Asthma
_Sleeping disorders _Digestive problems _Other

Regarding your child today:

Has your child ever been unconscious? Y N

Has your child ever used crutches or corrective braces? Y N

Is your child accident-prone? Y N

Has your child had any falls down steps? Y N

Has your child ever been involved in an auto accident? Y N

Has your child ever been hospitalized or had surgery? Y N

Has your child ever had any broken bones or sprain injuries? Y N

Is your child on any medications? Y N

Has your child been vaccinated? Y N

Is your child active in any particular sports? If yes which ones _____

Is your child hyperactive? Y N

Does your child have learning disorders? Y N

Does your child have poor posture? Y N

Is your child nervous, or has anyone suggested that your child was nervous? Y N

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 you may wish to share which may help us to better understand your child?_____

I hereby authorize The Healing Loft doctors and whomever they may designate to administer care as they deem necessary to my son/daughter.

Signed_____ Witnessed_____

Dated this _____ day of _____ 20__