

Child Information (5-15 yrs)

Renewed Hope Chiropractic and Wellness

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Child's Name _____

Child's Date of Birth: _____

Gender: Male Female

Parent(s) Names _____

Address _____ City _____ State _____ Postal Code _____

Parents' E-mail Address _____

Home Phone _____ Mobile Phone _____

Whom may we thank for referring your child to this office? _____

Health Concerns

Please list your child's health concerns according to their severity:

Concern	Rate of Severity 1=mild, 10=worst	When did it start? For how long?	If they had the condition before, when?	Did the problem begin with an injury?	What % of time is pain present?
1.					
2.					
3.					
4.					

Often seemingly unrelated symptoms can manifest as other health concerns:

(Please circle if your child has had any of the following)

- | | | | |
|-----------------------|----------------------|--------------------|---------------------|
| Headaches | Loss of taste | Weight gain | Upper back pain |
| Dizziness | Light sensitivity | Dental problems | Neck pain |
| Fainting | Face flushed | Fevers | Low back pain |
| Irritability | Bronchitis | Chest pressure | Stiffness |
| Depression | Pneumonia | Breast Pain | Reduced Mobility |
| Loss of balance | Difficulty breathing | Frequent colds | Numbness in leg(s) |
| Loss of concentration | Shortness of breath | Sinus congestion | Numbness in feet |
| Loss of memory | Asthma | Sore throat | Numbness in hand(s) |
| Ear buzzing | Urinary problems | Ear infection/pain | Weakness |
| Poor coordination | Constipation | Allergies | Muscle cramps |
| Vision changes | Diarrhea | Heartburn | Sleeping problems |
| Loss of smell | Weight loss | Bloating | Gas |

Other: _____

Pregnancy and Birth History

CHEMICAL STRESS

During the pregnancy did the mother:

Smoke? Yes No Drink Alcohol? Yes No
Use Recreational Drugs? Yes No Fall ill during pregnancy? Yes No
Take Prescription Medications? No Yes Please list: _____
Were any supplements taken during the pregnancy? No Yes Please list: _____

LABOR / BIRTH

Type of birth? Vaginal: Cephalic (head first) Breech (feet first) C-Section
Was labor induced? Yes No Duration of labor? _____

Was there any of the following assistance needed during birth? Please circle all that apply.

Forceps Cesarean Vacuum Extraction Induction Assisted Traction/Head Turning

Was there any evidence of birth trauma to the infant? Circle all that apply:

Bruising Odd shaped head Stuck in birth canal Fast or excessively long birth Respiratory depression Cord around neck

Was your child subjected to any of the following? Circle all that apply:

Silver nitrate drops in eyes Incubation Vitamin K shot Separation from you Hepatitis shot

Did your child spend any time in intensive care? Yes No If yes, how long? _____

Childhood History

PHYSICAL STRESS

Does your child have a preferred sleeping position? No Yes _____
Any falls or injuries down stairs, bicycle etc? No Yes _____
Any traumas resulting in fractures or stitches? No Yes _____
Any hospitalizations or surgeries? No Yes _____

Please list all surgeries your child has had:

1. Type _____ When _____ Doctor _____
2. Type _____ When _____ Doctor _____

Please list any accidents and/or injuries: auto, sports, or other (Especially those related to your child's present problems).

1. Type _____ When _____ Hospitalized? Yes No
2. Type _____ When _____ Hospitalized? Yes No
3. Type _____ When _____ Hospitalized? Yes No

Has your child ever had x-rays taken? No Yes When? _____ Where? _____

Does your child play sports? No Yes which sport(s)? _____

Is school backpack used? No Yes Weight of backpack? _____ kg/lbs

Approximate hrs spent at play per week? _____ Average hrs spent at computer/TV/video games per week? _____

CHEMICAL STRESS

Does your child have food allergies/ intolerances? No Yes, which _____

The type of diet your child usually follows is classified as: _____

Do you have any concerns about your child's eating habits? No Yes, explain _____

Please grade your child's dietary selections according to the following scale:

- | | | | | |
|--------------------------------|---------------------------------|----------------------------------|----------------------------------|------------------------------|
| D - Consumes this daily | W - Consumes this weekly | M - Consumes this monthly | O - Does not consume this | |
| ____ Eggs | ____ Fasting | ____ Fruit | ____ Fish | ____ Diet Food |
| ____ Organic Foods | ____ Coffee | ____ Beef | ____ Weight Control Diet | ____ Raw Vegetables |
| ____ Soft Drink | ____ Poultry | ____ Artificial Sweetener | ____ Whole Grains | ____ Fried Foods |
| ____ Seafood | ____ Cooked vegetables | ____ Refined Sugar | ____ Dairy | ____ Canned/Frozen vegetable |

Have you chosen to give your child vaccinations? No Yes

If so what vaccinations were given and at what age?

Was there any of the following symptoms: Circle all that apply

- Fever Un-consolable crying Irritability Arching of body Bowel disturbances
Feeding disturbances Drowsiness Other: _____

History of antibiotics? NO Yes how many courses of antibiotics has your child received? _____

Please list ALL medications your child currently takes or has taken in the past 6 months:

- Name _____ Dosage _____ For what? _____
Name _____ Dosage _____ For what? _____
Name _____ Dosage _____ For what? _____

Please list all nutritional supplements, vitamins, homeopathic remedies your child presently takes:

- Name _____ For what? _____
Name _____ For what? _____
Name _____ For what? _____

