HUNT FOR WELLNESS
Family Chiropractic & Nutrition

## PERSONAL INFORMATION FOR CHILDREN

Date / Fecha: _____ SSN:_____

First Name / Nombre: _____

Middle / Segundo: _____

Last Name: _____

Nickname / Apodo: _____

Birthday / Cumpleanos: _____ Age: _____

Parent's Name: _____

Address / Direccion: _____

City / State / Zip: _____

Phone Number / Telefono: _____

Parent's E-mail: _____

Is the child in school? [ ] Yes [ ] No What Grade? _____

School Name: _____

Parental Status:

| | |
|---|---|
| [ ] Married / Casado | [ ] Single / Soltero |
| [ ] Divorced / Divorciado | [ ] Separated / Separado |
| [ ] Widowed / Viudo | [ ] Unchanged / no cambio |

**Whom may we thank for referring you?**

_____

## IN CASE OF EMERGENCY / EMERGENCIA

Whom should we contact / Persona de contacto:

_____

Home # / Telefono de casa: _____

Other # / Otro numero: _____

Relation / Relacion: _____

Medical Doctor / Doctor Medico: _____

Doctor's # / # de doctor medico: _____

## CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. _____ and whomever he/she may designate as his assistants to administer chiropractic care as he deems necessary to my

_____

(Indicate relationship to minor).

Name of Child: _____

Name of Clinic: _____

This _____ day of _____, _____
(Month) (Year)

Signed By: _____
(Parent / Guardian)

Witnessed By: _____

# CHILD'S HEALTH HISTORY FORM

Hunt For Wellness
9422 South Tryon Street, Charlotte, NC 28273

Name: _____ Date: _____

Birth Date: _____ Age: _____ [ ] Male [ ] Female

Mother's Name: _____ Father's Name: _____

Reason for consulting our office: _____

_____

## HEALTH PROFILE


**Why is this form important?**

As a family chiropractic office, we focus on your child's ability to be healthy.

Our goals are first to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

******Do you know that chiropractic works toward correcting interference to life forces between the brain and the tissues, that is, we correct vertebral subluxations?** [ ] Yes [ ] No

## ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

******If your child has no symptoms or complaints, and is here for wellness services, please check [ ]**

****Others please briefly describe the chief area of complain, including the effect it has on the child.

_____

_____

If he/she is experiencing pain, is it: [ ] Sharp [ ] Dull [ ] Comes and Goes [ ] Travels [ ] Constant

What makes it worse? _____

It interferes with: [ ] School [ ] Sleep [ ] Walking [ ] Sitting [ ] Hobbies [ ] Other: _____

Other doctors seen for this problem:

Medical Doctor: _____ Chiropractor: _____ Other: _____

List medications the child is taking / the surgeries the child has had:

_____

_____

**** Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential. ****

**PREGNANCY:**

Were there any complications to the pregnancy? _____

Was Mom on any medications, prescriptions, or over-the-counter? [ ] Yes [ ] No

If yes, please explain: _____

Did Mom or Dad smoke during pregnancy? [ ] Yes [ ] No If yes, who? _____

Was the baby ever in the Breech position? [ ] Yes [ ] No

How many ultrasounds were performed? _____

**BIRTH AND DELIVERY:**

Where was the baby born? [ ] Home [ ] Hospital [ ] Birthing Center [ ] Other: _____

Were there any complications during delivery? [ ] Yes [ ] No Please explain: _____

Was the delivery: [ ] Vaginal [ ] C-section Where any devices used? [ ] Forceps [ ] Vacuum

How long was the labor? _____ How long was the delivery? _____

Was Oxytocin/Pitocin used? [ ] Yes [ ] No Was an Epidural administered? [ ] Yes [ ] No

Delivery: [ ] <36 weeks [ ] 37-42 weeks [ ] >42 weeks

Birth Weight: _____ Length: _____


**INFANCY:**

Was the infant vaccinated at birth? [ ] Yes [ ] No

Was there any prolonged use of medicines or an inhaler? [ ] Yes [ ] No

If yes, which? _____

Did the infant suffer any traumas such as serious falls or car accidents? [ ] Yes [ ] No

Has the infant been under regular chiropractic care? [ ] Yes [ ] No

**FEEDING HISTORY:**

Breast Fed: [ ] Yes [ ] No Explain: _____

Formula Fed: [ ] Yes [ ] No Explain: _____

Introduced to solids at: _____ months Cow's milk at _____ months

Food/Juice allergies or intolerances: [ ] Yes [ ] No Please list: _____

**CHILDHOOD YEARS:**

Does the child play youth sports? [ ] Yes [ ] No Explain: _____

Does the child take a multivitamin or any other nutritional supplements? _____

How many servings of fruits and vegetables does your child eat on a daily basis? _____

How many sodas (12 oz.) does your child drink per day? _____ How much water (in ounces) per day? _____

What position does your child sleep in? [ ] Back [ ] Side [ ] Stomach How many pillows does he/she use? _____

Has the child had any surgery? [ ] Yes [ ] No Explain: _____

Has the child fallen from a height over 3 ft.? [ ] Yes [ ] No Explain: _____

Has there been any prolonged use of meds? [ ] Yes [ ] No Explain: _____

Has the child suffered emotional traumas? [ ] Yes [ ] No Explain: _____

**HEALTH HISTORY:**

Has your child been vaccinated? [ ] Yes [ ] No Explain: _____

Any childhood diseases:

| | | |
|---|---|---|
| **[ ] Chicken Pox** | **[ ] Whooping Cough** | **[ ] RSV** |
| **[ ] Rubella** | **[ ] Mumps** | **[ ] Other: _____** |
| **[ ] Measles** | **[ ] Pertussis** | |

Check any of the following conditions your child has suffered from during the **last 6 months**:

| | | |
|---|---|---|
| **[ ] Ear Infections** | **[ ] Seizures** | **[ ] Growing Pains** |
| **[ ] Asthma/Allergies** | **[ ] ADHD** | **[ ] Neck Pain** |
| **[ ] Colic** | **[ ] Car accident** | **[ ] Back Pain** |
| **[ ] Scoliosis** | **[ ] Chronic Colds** | **[ ] Sleeplessness** |
| **[ ] Digestive Problems** | **[ ] Recurring Fevers** | **[ ] Other: _____** |
| **[ ] Bed Wetting** | **[ ] Headaches** | |

Has your child taken any antibiotics: [ ] Yes [ ] No

If yes, how many doses in the last 6 months? _____ Total during his/her lifetime: _____

**Please give us any other health information you feel would be helpful?** _____

_____

The statements made on this form are accurate to the best of my recollection and I request and give consent to Hunt For Wellness to examine and care for my child.

**Parent's Signature:** _____ **Date:** _____