Inner Balance Chiropractic

Child's Name: _____ Date: _____

Address: _____ City: _____ Zip Code: _____

Phone: _____ Email: _____

Date of Birth: / / Gender: M F Height: Weight:
Month Day Year

Have you consulted other health care professionals for this problem? Yes No
If yes, please list: _____

Other health problems: _____

Please check the conditions for which you child has been treated:

Ear Infections	*Growing Pains*	*Recurring Fevers*
Asthma/ Allergies	*Back/ Neck Pains*	*Bed Wetting*
Colic	*Seizures*	*Temper Tantrums*
Headaches	*Sinus Troubles*	*Bronchitis/ Upper Respiratory Infections*
Scoliosis	*Eczema/ Skin Problems*	*Attention Problems – ADD/ADHD*
Digestive Problems	*Constipation/ Diarrhea*	*Other (Specify)* _____

Are you content with your child's present level of health? Yes No
Please explain: _____

Previous Chiropractor: _____

Reason for Visits: _____

Has your child been treated by a physician for any condition in the previous 12 months? Yes No
If yes, please explain: _____

Is your child currently taking any medication? Yes No
If yes, please list along with reason: _____

Has your child taken any medication for an extended period of time in the past? Yes No
If yes, please list along with reason: _____

Number of does of antibiotics/ prescription your child has taken:
During the past 6 months: _____ During child's lifetime: _____
List: _____

Does your child take any herbal or vitamin supplementation? Yes No
If yes, please list: _____

ADDITIONAL INFORMATION

Name of Obstetrician/ Midwife: _____ Ultrasounds during pregnancy? Yes No

Medications during pregnancy? Yes No

Medications during labor/ delivery? Yes No
If yes, please list: _____

Were you induced? Yes No

Was your child at any time during your pregnancy in an intra-uterine constraining position, such as:
Breech Transverse Lie (side lying) Face/ Brow Presentation

Was your delivery vaginal? Yes No
Was your delivery C-Section? Yes No
If so was it planned or emergency? Planned Emergency

Were any of the following used during delivery? Forceps Vacuum Extraction Other
If other, please list: _____

Any complications during delivery? Yes No
If yes, please list: _____

Location of Birth: Hospital Birth Center Home
Weight: _____ Length: _____

Breast Fed: Yes No If yes, how many months? _____

Formula Fed: Yes No If yes, what type? _____

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

Food Sensitivities: _____

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxations (spinal nerve interference).

At what age was your child able to:
Hold head up: _____ Sit up: _____ Cross Crawl: _____ Walk Alone: _____

Has your child ever fallen from a high place? (bed, change table, sofa, down stairs, etc.) Yes No
If yes, please explain: _____

Is/was your child involved in any impact or contact sports? Yes No

Has your child ever been involved in a car accident? Yes No
If yes, please explain: _____

Has your child ever been seen on an emergency basis? Yes No
If yes, please explain: _____

Other Traumas? Yes No
If yes, please explain: _____

Prior Surgery? Yes No
If yes, please explain: _____

Has your child received vaccinations? Yes No

Does your child exercise? Yes No
What type of exercise: _____
_____

Please indicate whether your child has experience any of the following illnesses, and if so, at what age:

Chicken Pox	Age: ____	Mumps	Age: ____	Rubella	Age: ____
Whooping Cough	Age: ____	Rubeola	Age: ____	Other	Age: ____

If "Other", please list: _____
_____

Additional Comments:
_____
_____
_____
_____
_____

CONSENT FOR CARE

Our Office is dedicated to assisting you in recovering your health naturally. Please review the next paragraph and sign in the area provided.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment to the Doctor. All fees are due at time of service.

I hereby request and consent to the performance of Chiropractic examinations, adjustments and other chiropractic procedures such as, and if necessary, diagnostic x-rays on me by the doctor of chiropractic named below and/or anyone working in this office authorized by the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor of chiropractic/staff members named below and/or with other office personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including but not limited to, muscle strains, and sprains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. I have read the above mentioned chiropractic procedure. I intend this Consent Form to cover the entire course of treatment for my present condition.

Signature of Parent or Guardian: _____ Date: _____
On behalf of: _____ Age: _____
Please print name of child

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