

# Advanced Chiropractic Pediatric Consultation

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent Contact #: \_\_\_\_\_ Pediatrician/Family MD: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Social Security # \_\_\_\_\_ Marital Status:  Single  Married

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse's Name/DOB: \_\_\_\_\_ Spouse's Social Security #: \_\_\_\_\_

Number of children/Names/Ages: \_\_\_\_\_

Name and number of Emergency Contact: \_\_\_\_\_

The majority of children have experienced hundreds of impacts that cause vertebrae to become misaligned or Subluxated. What we need to do now is discover several of the traumas your child has suffered.

What was your child's birth like? Easy / Stressful / Complicated / Surgical

How long was the entire labor? \_\_\_\_\_ How long did you actually push for? \_\_\_\_\_

Were you induced?  Yes  No Nerve Block?  Yes  No C-Section?  Yes  No

Was there any pulling on the head?  Yes  No |  Mid-Wife OBGYN  Forceps/Vacuum Extraction

Science has shown that 47% of all children fall on their heads by the age of one and have at least 200 major falls by the age of five years old.

When was your child's most recent fall? \_\_\_\_\_ Was any care given?  Yes  No

Was he/she checked by a chiropractor for subluxation?  Yes  No

And the fall before that? \_\_\_\_\_ Was any care given?  Yes  No

Was he/she checked by a chiropractor for subluxation?  Yes  No

What sports or recreational activities does your child do? \_\_\_\_\_

When was your child's most recent stress/strain/injury while doing these activities? \_\_\_\_\_

Was any care given?  Yes  No Chiropractic adjustment?  Yes  No

Has your child ever been involved in a motor vehicle accident as a passenger?  Yes  No

Briefly describe: When/Details? \_\_\_\_\_

Child Seat?  Yes  No Seat belt?  Yes  No Front or Back Seat?  Front  Back

Was any care given?  Yes  No Chiropractic adjustment?  Yes  No

This information is important. Thank you for explaining your child's history of accidents & traumas. This will help the doctor better understand where the spine is damaged or Subluxated. What we need to do now is ask you a few questions regarding your child's current health concerns.

**CHILD'S CURRENT PROBLEM:**

**Purpose of this visit:** \_\_\_Wellness Check-up \_\_\_Injury or Accident \_\_\_Other

Please explain:

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If your child is experiencing **Pain/Discomfort** please identify where and for how long:

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1. **When did the** Problem first begin? Date \_\_\_\_\_ \_\_\_Unknown \_\_\_Gradual  
\_\_\_Sudden

2. **Ever had** this problem **before**? No\_\_\_Yes\_\_\_ If yes when?  
\_\_\_\_\_

3. Any **bowel or bladder** problems since this problem began?: If yes, Describe:  
\_\_\_\_\_

4. Have you seen any **other doctors** for this problem? No Yes If yes who?  
\_\_\_\_\_

5. How long ago? \_\_\_\_\_Days \_\_\_\_\_Weeks \_\_\_\_\_Months \_\_\_\_\_Years

6. What were the results of past treatment?  
\_\_\_\_\_

7. How is this problem **NOW**:

- Rapidly Improving  Improving Slowly  About the Same  Gradually Worsening  
 On & Off

8. Please list any **medication taken** for this problem:  
\_\_\_\_\_

**Has Your Child Ever Suffered From:**

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- |                     |  |                   |  |
|---------------------|--|-------------------|--|
| Headaches           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint Problems    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Orthopedic Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Constipation      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Digestive Problems  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Growing Pains     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Behavioral Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Earaches  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizziness           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Backaches         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Neck Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diarrhea          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Poor appetite       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Troubles    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ADD/ADHD            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Poor Posture      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arm Problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scoliosis         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stomach Aches       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Seizure/Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Colds/Flu         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Leg Problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Walking Trouble   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Reflux              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bedwetting        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Muscle Pain         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Colic             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Trouble       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleeping Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Broken Bones        | <input type="checkbox"/> Yes <input type="checkbox"/> No |                   |  |

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Specify: \_\_\_\_\_

**Falls:**

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- |                   |  |
|-------------------|--|
| Baby Walker       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bed/Couch         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Crib              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Swing             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bicycle           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Chair        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Slide             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stairs            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Changing table    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Monkey Bars       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Skateboard/Scates | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Other:

Other:

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# Advanced Chiropractic

\_\_\_\_\_  
Parent or Legal Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date

Under the terms and condition of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

## Studies at Columbia University

Traumatic birth syndrome whether it results in immediate symptoms or diminishes your human potential over the course of your lifetime must be dealt with immediately.

## Rockefeller Institute      Dr Arpad DeNagy

Determined that interference to the nervous system, due to spinal stress, resulted in serious damage within a short period of time. He recommends that stabilizing biomechanical care should begin as soon after birth as possible. He further indicated "Spinal stress tragedy may take sixty years to fully develop."

## Boston University      Arthur Janov Ph.D. (pathologist)

The entire birth process, from conception and pregnancy to delivery and post-delivery, can lay the foundation for later mental and physical disease. "The real cause of our demise is not diseases, but the spinal stress that happens at birth. This robs us of our innate potential for a very long, very healthy, and very happy life. The child will have less than optimal physical, mental, and social well-being."

## Janson Edwards MD Ph.D.

"The quality of healing is directly proportional to the functional capability of the central nervous system to send and receive nerve messages."