

Network Chiropractic Wellness Center
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?

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 Dr. Omri Sitton to administer care as he deems necessary to my son/daughter

Signed_____ Witnessed_____

Dated this _____ day of _____ 20____