Child's Health History

Larkfield *family* Chiropractic

CHILD'S PERSONAL DATA

Today's Date: _____

Name: _____

Age: _____ **Date of Birth:** _____ **Gender:** ____ M ____ F

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Names & Ages of Siblings: _____

Parent A	Parent B
Name: _____	**Name:** _____
Home phone: (_____) _____	**Home phone:** (_____) _____
Cell phone: (_____) _____	**Cell phone:** (_____) _____
Employer: _____	**Employer:** _____
E-mail: _____	**E-mail:** _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Larkfield Family Chiropractic can address for your child?

_____

Please indicate below how these concerns are affecting your child's quality of life. ***(Circle all that apply)***

School	Exercise/Sports	Walking
Playing	Sleep	Attention/Focus
Communication	Eating	Daily Routine

Other: _____

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ❑Y ❑ N

Name of D.C. _____

Reason _____

How long? _____ **Date of last visit** _____

Why was care stopped _____

Have you consulted or do you regularly consult any of the following providers for your child?

Check all that apply

❑ Medical Physician	❑ Naturopath	❑ Acupuncturist	❑ Homeopath	
❑ Massage Therapist	❑ Psychotherapist	❑ Energy Healer	❑ Other	

Reason: _____

Health, Vitality & Chiropractic Care

The primary system in the body which coordinates health is the nerve system. The vertebrae, bones of the spinal column, surround and protect the delicate nerve system. Injury to the spine and nerve system is a condition called vertebral subluxation. Vertebral subluxation results in nerve malfunction due to vertebral/spinal misalignment. Vertebral subluxations can have physical, emotional, and chemical causes and effects.

The information below helps the chiropractor see the types of PHYSICAL, CHEMICAL & EMOTIONAL stresses your child has been subjected to; how they may relate to his/her present spinal, nerve and health status and whether they may have played a part in creating vertebral subluxations.

PREGNANCY & BIRTH

The birth process can be traumatic to a baby's spine and cause interference to the nervous system

During pregnancy did the mother:

Experience any illnesses, difficulties, or trauma? ❑Y ❑ N List:_____

Take any drugs/medications? ❑Y ❑ N List: _____

Smoke or consume alcohol? ❑Y ❑ N List: _____

Was the delivery premature? ❑Y ❑ N Weeks: _____Weight: _____

Approximately how long did labor last? _____ hours

Was labor artificially induced? ❑Y ❑ N

Was the child in a breech position (butt down) or otherwise mispositioned? ❑Y ❑ N

Please check where the child was born & if any of the following were administered during labor and birth.

❑ Home birth ❑ Hospital ❑ Vaginal ❑ Water birth ❑ Caesarean
❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications _____
❑ Pitocin ❑ Episiotomy ❑ Manual traction of the neck

Please check all that apply to the child's status immediately after birth: APGAR Score _____

❑ Jaundice ❑ Respiratory problems ❑ Broken bones:
❑ Feeding problem ❑ Displaced joints ❑ Other conditions:

Was the baby breastfed? ❑Y ❑ N For how long? _____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Please check all that apply to your child and give any necessary details:

- **❑ Uncoordinated/Accident prone**
- **❑ Has been hospitalized**
- **❑ Had a severe trauma or concussion**
- **❑ Been in an automobile accident**
- **❑ Has fractured a bone or dislocated a joint.**
- **❑ Has/had a chronic illness.**
- **❑ Has had surgery.**

What physical activities does your child participate in?

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ❑Y ❑ N

If yes, please check all vaccinations the child has received and at what age they were administered:

❑ DPT _____ ❑ Hepatitis _____ ❑ Chicken Pox _____
❑ Polio _____ ❑ MMR _____ ❑ Flu _____
Other _____

Please describe any and all reactions to vaccine(s)

Please check all that apply and give any necessary details:

- ❑ **Child exposed to second hand smoke.**
- ❑ **Has taken antibiotics. *Explain:* _____**
- ❑ **Currently taking medication. *Explain:* _____**
- ❑ **Currently taking supplements. *Explain:* _____**
- ❑ **Has allergies. *Explain:* _____**

What treatments have you used? _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below: *(check all that apply)*

❑ Academic pressure ❑ Loss of a loved one ❑ Bullying ❑ Relocation
❑ Lifestyle change ❑ Parents' divorce ❑ Loss of a pet ❑ New sibling

Does your child have difficulty interacting with schoolmates or friends? ❑Y ❑ N

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior?

❑Y ❑ N

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like my child to experience the following benefits from Chiropractic Care: *(Check all that apply)*

- ❒ **Symptomatic relief of a problem**
- ❒ **Prevention of future problems**
- ❒ **Healthier spine and nerve system**
- ❒ **Optimal health on all level**
- ❒ **Other _____**

Thank you for choosing Larkfield Family Chiropractic!

Dr. Michelle Kobbe
631.262.0015 | 534 Larkfield Road | East Northport, NY 11731

Consent Form

Larkfield *family* Chiropractic

PLEASE READ AND SIGN

Patient Name: _____

I hereby request and authorize Michelle Kobbe, D.C. to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor [son][daughter] named_____. This authorization also extends to all other doctors and office staff members and is intended to include referral for radiographic examination at the doctor's discretion.

As of the date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Name: (printed) _____ **Date:** _____

Parent or Legal Guardian's Name: (printed)_____

Signature: _____

Please note below any withdrawal of consent to any of the above statements:

Signature: _____ **Date:** _____

Welcome to Larkfield Family Chiropractic!

Dr. Michelle Kobbe
631.262.0015 | 534 Larkfield Road | East Northport, NY 11731