MONARCH

FAMILY CHIROPRACTIC

## ABOUT THE PATIENT

Child's Name: ______________________ Today's Date: ___/_____/______ Birth Date: ___/___/______ Age: _________

Parent's Names: _________________________________ Siblings' Names & Ages:________________________________

Address: ________________________________________City:________________ State: ________ Zip:____________

Phone # Cell/ Home: ____________________ Cell Carrier:________________________________ (for text reminders)

Who may we thank for referring you?______________________________

Name of Family Doctor(s): ____________________________________________________________________________

Has your child ever been to a Chiropractor before? ☐ Yes ☐ No If yes, what was the date of the last visit?______________

What was the reason of the last visit?__________________ Other professionals seen for this condition?______________

Results with that treatment?______________________________________________________________________________

Recent tests done (list date beside): ☐ Bloodwork________ ☐ Urinalysis________ ☐ X-Rays________ ☐ Other__________

Please mark the purpose for your child's visit:

☐ Crisis Management ☐ Early Detection of Problems ☐ Maximizing Normal Growth and Development

## CURRENT HEALTH PROFILE

What brings you into our office? Please briefly describe your chief concern, **including the impact it has had on your life**. If you have no symptoms or concerns right now skip to the General History Section.

| Health Concerns: | Severity: 1=Minimal 10=Extreme | When did this start?: | Are the symptoms constant or intermittent? | Did the problem begin with an injury?: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

What makes it better?__________________________________________________

What makes it worse? __________________________________________________

Is the problem worse during a certain part of the day? ☐ Yes ☐ No

If yes, when?__________________________________________________

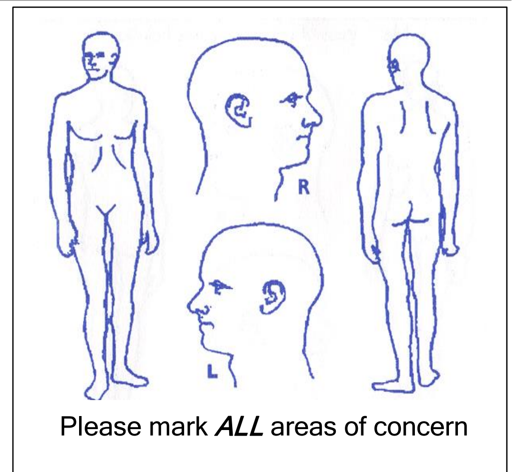
Does this interfere with the child's sleep? ☐ Yes ☐ No

Does this interfere with the child's eating? ☐ Yes ☐ No

Does this interfere with the child's daily routine? ☐ Yes ☐ No

Is this becoming worse? ☐ Yes ☐ No

Notes:____________________________________________________________




Please mark *ALL* areas of concern

## GENERAL HEALTH HISTORY

Since the Nervous System controls everything in your body, it is quite likely that your current health challenges are related to the problems you are seeking care for in our office. **Please check the following symptoms that apply to your health:**

| | | |
|---|---|---|
| □ Headaches | □ Chest Pressure | □ Weight Loss |
| □ Dizziness | □ Breast Pain | □ Weight Gain |
| □ Irritability | □ Frequent Colds | □ Dental Problems |
| □ Fatigue | □ Sinus Congestion | □ Fevers |
| □ Depression | □ Sore Throats | □ Heart Palpitations |
| □ Stiffness | □ Ear Pain/Infections | □ Numbness in Feet |
| □ Numbness in Leg(s) | □ Asthma | □ Numbness in Hand(s) |
| □ Fainting | □ Cold Sweats | □ Weakness |
| □ Ears Buzzing | □ Bronchitis | □ Heartburn |
| □ Poor Coordination | □ Pneumonia | □ Muscle Cramps |
| □ Vision Changes | □ Difficulty Breathing | □ Upper Back Pain |
| □ Loss of Memory | □ Shortness of Breath | □ Neck Pain |
| □ Loss of Smell | □ Allergies | □ Low Back Pain |
| □ Loss of Taste | □ Constipation | □ Radiating Pain |
| □ Light Sensitivity | □ Diarrhea | □ Sleeping Problems |
| □ Face Flushed | □ Urinary Problems | □ Loss of Concentration |
| □ Reduced Mobility | □ Bloating/Gas | □ Loss of Balance |

□ Other_______________________________________________________________________

## BIRTH HISTORY

**What was the child's gestational age at birth?** _____ weeks **Birth weight** ________lbs. _______oz.
**Birth length** ________ inches **Was your child's birth:** □ At home □ In a Birthing Center □ Hospital □ Other
**Was the birth considered:** □ Medical □ Midwife **Duration of birth:** _______ hours
**Was child born:** □ cephalic (head first) □ breech (feet first) **Was labor:** □ spontaneous □ induced
**Were there any complications?** □ Yes □ No
If yes, please explain ______________________________________________________________
**Assistances used during delivery:** □ Forceps □ Vacuum extraction □ C-section □ Episiotomy
**Were medications or epidurals given to the mother during birth?** □ Yes □ No
**APGAR score:** At Birth ______/10 After 5 minutes___/10
**Is there anything else we need to know about the birth?** □ Yes □ No
If yes, please explain ______________________________________________________________

## GROWTH AND DEVELOPMENT

**Was the infant alert and responsive within 12 hours of delivery?** □ Yes □ No
If no, please explain ______________________________________________________________
**At what age did the child:** Respond to sound _______ Follow and Object _______ Hold up Head _______
Vocalize _______ Sit Alone _______ Teethe _______
Crawl _______ Walk _______
**Does your child sleep:** □ Front □ Back □ Side **Do you consider the child's sleeping pattern normal?** □ Yes □ No
**How many hours per day?** ________________ If no, please explain ____________________________________

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## FAMILY HISTORY

**Please note** any health issues that are present with family, such as parents, siblings, significant other or children:

**Father's Side:** ☐ Cancer ☐ Stroke ☐ Arthritis ☐ Kidney Disease ☐ Dementia ☐ Diabetes ☐ Other______________
**Mother's Side:** ☐ Cancer ☐ Stroke ☐ Arthritis ☐ Kidney Disease ☐ Dementia ☐ Diabetes ☐ Other______________

**Is there any other family history you want us to know?**________________________________________________

## PHYSICAL STRESSES

**Any trauma to the mother during pregnancy?** ☐ Yes ☐ No
If yes, please explain___________________________________________________ ___________________
**Any evidence of birth trauma to the infant?** ☐ Bruising ☐ Odd Shaped Head ☐ Stuck in Birth Canal
☐ Respiratory depression ☐ fast or excessively long birth ☐ cord around neck
**Any falls from couches, beds, change tables, etc?** ☐ Yes ☐ No
If yes, please explain ______________________________________________________________________
**Any trauma resulting in bruises, cuts, stitches, or fractures?** ☐ Yes ☐ No
If yes, please explain ______________________________________________________________________
**Any hospitalizations or surgeries?** ☐ Yes ☐ No
If yes, please explain ______________________________________________________________________

**Any sports played?** ______________________________________________________________________________

**Is a school backpack used?** ☐ Yes ☐ No **Is it** ☐ Heavy **or** ☐ Light?

## CHEMICAL STRESSES

**Was this child breast-fed?** ☐ Yes ☐ No If yes, how long? ________________________________________
**Formula introduced at what age:** _______________ **Which formula?** ___________________________________________
**Introduction of cow's milk at what age:** ___________ **Began solid foods at what age:** ______________________________
**Types of solid foods:**__________________________________________________________________________________
**Food/Juice intolerance?** ☐ Yes ☐ No **Type:** _____________________________________________________________
**Is your child on or have taken any medications?** ______________________________________________________________
**During the mother's pregnancy:**
**Did the mother smoke?** ☐ Yes ☐ No How much? _______________________________________________________
**Drink alcohol?** ☐ Yes ☐ No How much? __________________________________________________________
**Any illnesses during the pregnancy?** ☐ Yes ☐ No If yes, describe:___________________________________________
**Any supplements taken during pregnancy?** ☐ Yes ☐ No If yes, describe:_______________________________________
**Any drugs taken during pregnancy?** ☐ Yes ☐ No ______________________________________________________
**Any ultrasounds?** ☐ Yes ☐ No How many:___________ Reasons for being done:______________________________
**Any invasive procedures during pregnancy (ie amniocentesis, Chorionic villi sampling, etc.)?** ☐ Yes ☐ No
If yes, please explain ___________________________________________________________________________
**Any pets at home?** ☐ Yes ☐ No _______________________________________________________________________
**Any smokers in the home?** ☐ Yes ☐ No
**Any antibiotics given?** ☐ Yes ☐ No If yes, reason: ______________________________________________________
**Is the diet organic?** ☐ Yes ☐ No **Do you use 'green products' in your home for cleaning?** ☐ Yes ☐ No
**How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet?** ☐ Never ☐ On weekends
☐ A few times per week ☐ Daily ☐ Nearly each meal ☐ On special occasions
**Are you aware of the impact of nutrition on children's behavior?** ☐ Yes ☐ No
**Would you like information on nutrition for your child?** ☐ Yes ☐ No

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## PSYCHOSOCIAL STRESSES

Any difficulties with lactation? □ Yes □ No ______________________________

Any problems with bonding? □ Yes □ No ______________________________

Any behavioral problems? □ Yes □ No ______________________________

Any inattention? □ Yes □ No ______________________________

Any hyperactivity or restlessness? □ Yes □ No ______________________________

Any compulsiveness? □ Yes □ No ______________________________

Any difficulties at daycare or school? □ Yes □ No ______________________________

Any challenges with learning deficiencies? □ Yes □ No ______________________________

Any night terrors, sleep walking, difficulty sleeping? □ Yes □ No ______________________________

Any prolonged temper tantrums or separation anxiety? □ Yes □ No ______________________________

Is the child in day care? □ Yes □ No ______________________________

Age of child when began daycare? ______________________________

Is there a nanny or regular sitter during the day if both parents work? □ Yes □ No ______________

Is the child home schooled? □ Yes □ No ______________by Whom? ______________

Average number of hours of television per week? ______________________________

Average number of hours of video games/computer time per week? ______________________________

Does your child have a cell phone? □ Yes □ No **How often do they text or use the phone?** ______________

Do you feel that your child's social and emotional development is normal for their age? □ Yes □ No

______________________________________________________________

## ADDITIONAL CONCERNS

If we have not listed current health challenges on the above list, **please now list additional health concerns in the space below**: ______________________________

______________________________________________________________

______________________________________________________________

## CONSENT FOR EXAM

**Authorizing Consent for examination of a Minor (under 16 years): Please Read Carefully**

In order for the health professional as indicated below to make a determination on the suitability of my child's/guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child's interests.

Name: ______________________________ Date: ______________________________

Signature: ______________________________ Witness: ______________________________

Doctors of Chiropractic: *Dr. Miaken Zeigler, D.C. & Dr. Kristen Zawada, D.C.*