CHILDREN'S PERSONAL HEALTH PROFILE

Name:			Date:	MSP#
Address:			City:	Postal Code:
E-mail Address:			Home Phone: ( )	Parent's Work Phone: ( )
Gender: ☐ M ☐ F	Date of Birth: MM DD YY	Age:	Parent's Cell Phone: ( )	
Parents'/Guardians' Names:				
How were you referred to our office?	Have you ever received chiropractic care before? ☐ No ☐ Yes Date of last visit? Who was the Doctor? Years under care? Where was the Doctor?			
Person to contact in an emergency:			Phone: ( )	

Please take a moment to complete the following questions that are designed to maximize your child's health. Many types of stress (physical, mental, chemical) can interfere with your child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please remember to ask questions.

1. Is this visit for a wellness checkup and prevention or a specific concern?
   If there is a specific concern please describe:

   _____

2. Circle Appropriately:

   Birth Place: Home/ Hospital **Birth Type:** Vaginal/ C-Section/ Breech

   Procedures: Forceps/ Vacuum Extraction/ Induced/ Other

   _____

3. Which sports does your child participate in?_____

4. According to the National Safety Council, approximately 50% of infants have had a fall from a bed, changing table, etc., during their first year of life. Has this happened to your child?
   ❒Yes ❒ No

   Please expand on this fall in question 5 and expand on other impacts that you recall.

5. In your child's whole life, what were his/her 5 most serious physical traumas/stresses (eg. automobile jarring/impacts, school stress, recreational activities, sports, falls)

Trauma	Date of trauma
1)	
2)	
3)	
4)	
5)	

6. Check any of the following conditions your child has suffered from during the past year:
   ❒ Ear Infections ❒ Chronic Colds ❒ Seizures ❒ Scoliosis ❒ Headache
   ❒ Asthma/Allergies ❒ Digestive Problems ❒ ADHD ❒ Recurring Fevers
   ❒ Temper Tantrums ❒ Growing or Back Pains ❒ Colic
   ❒ Bed Wetting ❒ Car Accident ❒ Other _____

7. How many prescriptions of antibiotics has your child taken in the last year? _____
   Estimate how many in your child's lifetime: _____

8. How many other prescription or over the counter medications has your child taken in the last year? _____

   Please name them:_____

9. How many different vaccinations has your child had in their lifetime?

   _____

On a scale of 1 to 10 (10 being the highest), rate your commitment if chiropractic care can help correct this problem or prevent future health problems *(circle number):*

1 2 3 4 5 6 7 8 9 10

Not committed at all — Somewhat committed — Highly committed

I give Dr. Jenkins permission to perform a comprehensive spinal health exam with the intent to determine if my child has any functional or structural spinal problems.

_____ _____

Parent/Guardian Signature Date