

Your Child's Life Story & Vital Information

Name _____ Age _____ Birthday! _____
Address _____ City _____ State _____ Zip _____
Names of Siblings _____
Parent's/Guardian's Names _____
Parent's/Guardian's Phones _____
Who can we thank for referring you to **Brilliant Life**? _____
Is your child currently benefiting from Chiropractic Care? _____ Last Visit? _____
What results would you like to see for your child from care here? _____

Have you consulted with other health care practitioners for this reason? _____

Many of the health challenges that people face originate from stressors experienced during developmental years (including gestation and birth). These stressors (traumas) may be emotional, mental, physical, or chemical. *Please answer all of the following questions to the best of your ability.*

During Pregnancy, did the mother:

- Take medications? Type: _____
- Smoke or consume alcohol or drugs? Details: _____
- Experience any illnesses? Type: _____
- Undergo a lot of stress? Details: _____
- Receive ultrasounds or other forms of radiation? _____

Birth Process:

- Birthplace: Home Hospital Birthing Center
- Type of Birth: Vaginal C-section
 Breech (feet first) Cephalic (head first) Occiput Posterior (facing forward)
- Procedures: Forceps Vacuum Extraction
- Birth Assistants: M.D. Midwife Doula

Did the person assisting the delivery twist or pull the baby during the delivery? _____

How long did labor & delivery last? _____

What was the mother's position during labor? Back Side Sitting Standing Other

Did the mother have an episiotomy? Yes No

Was labor chemically induced? Yes No

What (if any) drugs were administered during the labor process? _____

What was the child's gestational age at birth? _____

Was your child breast-fed? _____ How long did breast-feeding continue? _____

Did your newborn child experience any of the following after birth?

- Silver Nitrate eye drops Vitamin K injection Hepatitis injection
- Incubation (how long) _____ Separation from mother (how long) _____

Vaccinations

Have you chosen to vaccinate your child? Yes No

If yes, check all vaccinations received: DPT MMR Polio
 Chicken Pox Hepatitis Flu
 other _____

Describe any reactions to the vaccine(s): _____

Growth and Development

At what age did your child:

Follow an object: _____

Respond to sound: _____

Hold up head: _____

Vocalize: _____

Sit unassisted: _____

Teethe: _____

Crawl: _____

Walk: _____

Has your child's body communicated any of the following?

- | | | |
|---|--|-------------------------------------|
| <input type="radio"/> vision problems | <input type="radio"/> pink eye | <input type="radio"/> constipation |
| <input type="radio"/> headaches | <input type="radio"/> ear infections | <input type="radio"/> asthma |
| <input type="radio"/> sleeping difficulty | <input type="radio"/> tubes in the ears | <input type="radio"/> colic |
| <input type="radio"/> irritability | <input type="radio"/> attention problems | <input type="radio"/> allergies |
| <input type="radio"/> skin problems | <input type="radio"/> frequent colds | <input type="radio"/> bedwetting |
| <input type="radio"/> breathing problems | <input type="radio"/> digestive problems | <input type="radio"/> hyperactivity |
| <input type="radio"/> other _____ | | |

Is your child accident prone? _____

Average number of hours your child watches television, plays on the computer, or plays electronic games each week _____

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

If "no", please explain _____

Has your child experienced any night terrors or sleep walking? _____

Has your child:

Been hospitalized/undergone surgery? No Yes:

Had a severe fall? No Yes:

Been in a car accident? No Yes:

Any traumas resulting in bruises, fractures, or stitches? Yes No

Any sports participation? (Please list sports, hours per week, years played) _____

Is a school backpack used? _____ Please describe (heavy, light, on wheels, etc): _____

Has your child every taken antibiotics (OTC or prescription)? Yes No

If yes, how often, and why? _____

Has your child ever taken or is currently taking other medications? Yes No

If yes, please list medications and reasons for taking _____

Is your child on a particular diet (Gluten and/or dairy free, etc)? _____

Does your child consume:

- | | | |
|---|------------------------------------|--|
| <input type="radio"/> caffeine | <input type="radio"/> soda | <input type="radio"/> sugar |
| <input type="radio"/> artificial sweeteners | <input type="radio"/> fast food | <input type="radio"/> processed foods |
| <input type="radio"/> unfiltered tap water | <input type="radio"/> fresh fruits | <input type="radio"/> fresh vegetables |

What changes in your child's health or behavior would you like to see (if any)? _____

Is now a good time for you and your family to commit to cultivating these changes? Yes No

Who is on your child's health care team now? (pediatrician, naturopath, nutritionist, acupuncturist, etc) _____

Financial Policy: The medical insurance industry pays for the treatment of symptoms and disease rather than the maintenance of our well-being. As chiropractic is not a treatment nor a cure of disease, we require your investment to be paid directly to us at time of service. However, we will provide you with a form to submit your claims to your insurance company if you desire. Your insurance policy is between you and your insurance company, not between your insurance company and us.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment of all bills incurred at this office. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

Authorization for Care of a Minor

I have read and understand the financial policy. I hereby authorize Dr. Martin to administer care as deemed necessary to my son/daughter.

Name of Child

Date

Parent, Guardian or Spouse Authorizing Care

Date

Our mission is to empower and inspire our community to realize their incredible potential for optimal health. Recognizing that health is the full expression of mind, body, and spirit, we seek to remove any blocks to that expression through gentle and specific chiropractic care. With compassion, understanding and love, we serve and educate our community about how to live a Brilliant Life.

Chiropractor's Notes:
(please leave blank)