



CHILDREN'S PERSONAL HEALTH PROFILE

| | | | | | |
|---|----------------------------|---|--------------------------|---------------------------------|---------------------------------|
| Name: | | | Date: | | |
| Address: | | City: | | Postal Code: | |
| E-mail Address: | | | Home Phone: () () | | Parent's Work Phone: () () |
| Gender: <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of last visit? Who was the Doctor? Years under care? Where was the Doctor? | | | |
| Extended Health Insurance: <input type="checkbox"/> No <input type="checkbox"/> Yes Company: | | | \$ Participation / Year: | | Renewal Date (ie. Jan 1): |

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 Type: Vaginal / C-Section / Breech
 Procedures: Forceps / Vacuum Extraction / Induced / Other _____

3. Which Contact sports does your child participate in? Circle Appropriately:
 Soccer / Football / Gymnastics / Karate / Hockey / Basketball / Dance / Other:

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

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) | |

