WHOLE FAMILY
CHIROPRACTIC

Welcome!

Your first visit to our center is an opportunity for us to learn all about you and your family. It is a time for you to share with us where you are now in your health and life, as well as what you would like to move toward. *And away we go!*

Personal Information - Pediatric

Name _____ Birth Date ____/____/____ Today's Date ____/____/____

Phone (H) _____ (W) _____ Ext. _____ (Cell) _____

Address _____
Number & Street City State Zip

Parent's Email Address _____

Mother's Name _____ Father's Name _____

Are parents ☐ Single ☐ Married/Partnered ☐ Widowed ☐ Divorced

# of Kids in family ____ How many at home? _____ Names & ages _____

_____

Has your child been to a chiropractor before? ☐ Yes ☐ No Approximate date of last visit ____/____/____

Dr.'s Name/City/State _____ Good results? ☐ Yes ☐ No

Is your child under care of any other doctor? Yes/No If Yes, the condition being treated for _____

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

Your child's favorite hobbies or interests _____

Labor and Delivery History

Did you and/or your child experience any of the following during the labor/delivery

☐ Hospital birth	☐ Home birth	☐ Birthing home	☐ The labor was induced
☐ Long and/or difficult labor	☐ The delivery was rapid	☐ Placenta previa	☐ Forceps or suction cup used
☐ Elective c-section	☐ Emergency c-section	☐ Fetal distress	☐ Cord around the neck
☐ The child was premature (2+ weeks)	☐ The child was a "blue baby"	☐ Breech birth	

Please list reasons for any interventions/complications during labor and delivery _____

_____

Rank mother's general stress level (0-10) during pregnancy _____

Did mother smoke during pregnancy? Yes ◯ /No ◯

Any illness of mother during pregnancy?Yes ◯/No ◯ If yes, please explain_____

List any drugs/medications (including over-the-counter) taken during pregnancy _____

_____

Let's Find Out Why You're Here…

Reason for seeking chiropractic care _____

_____

Any other specific concerns? _____

If seeking chiropractic for a specific concern, has your child been treated for this concern before? Yes ◯/No ◯

Please explain _____

When did this concern begin? _____

List all current medications and conditions being treated _____

_____

List any vitamins/herbs/homeopathics/other your child is taking _____

_____

Has child received any vaccinations? Yes ◯ /No ◯ If yes, list any reactions

Has your child received any antibiotics? If yes, how many times and list reason _____

_____

List any past surgeries or hospitalizations and dates _____

_____

List any past accidents and dates _____

List any injuries _____

Has your child ever been under chiropractic maintenance care? _____

Do you know what a subluxation is? If yes, please describe _____

_____

Is/was your child breastfed? Yes ◯/No ◯ If yes, how long? _____

Any difficulty with breastfeeding? Explain. _____

Is/was your child formula fed? Yes ◯/No ◯ If yes, how long? _____

Any difficulty with bonding? Yes ◯/No ◯ If yes, please explain _____

Any behavioural problems? Yes ◯/No ◯ If yes, please explain _____

Does your child have regular bowel/bladder movements? Yes ◯ /No ◯

Quality of Life Inventory

If your child has experienced any of the following, please indicate by writing **C** (Current), **P** (Past) or **CP** (Current and Past).

Select ___ Fatigue	Select ___ Sinus problems	Select ___ Digestion problems	Select ___ Chronic ear infections/earaches
Select ___ Diabetes	Select ___ Frequent colds	Select ___ Nervousness	Select ___ Serious fall(s) or repetitive falls
Select ___ Fainting	Select ___ Head injury	Select ___ Sleeping problems	Select ___ Illnesses with a high fever
Select ___ Asthma	Select ___ Serious illness	Select ___ Difficulty focusing	Select ___ Trouble with bladder control
Select ___ Anxiety	Select ___ Meningitis	Select ___ Seizures/Convulsions	Select ___ Joint or muscle problems
Select ___ Cold Sweats	Select ___ Heart problems	Select ___ Urinary problems	Select ___ Nausea
Select ___ Weakness	Select ___ Loss of balance	Select ___ Mood swings	Select ___ Neck or back problems
Select ___ Dizziness	Select ___ Skin Conditions	Select ___ Low energy/tired	Select ___ Ringing in ears
Select ___ Headaches	Select ___ Ulcers	Select ___ Allergies to foods	Other_____
Select ___ Migraines	Select ___ Cancer	Select ___ Environmental allergies	

Let's Make Sure We're On the Same Page…

When an individual or family seeks and is accepted into a program of **function-based** chiropractic care, it is essential for all parties to be working toward the same objectives. We have only one goal, and it is important that everyone understands both our objective and the methods we will use to move consistently toward that objective.

Your care in our center is not a substitute or alternative for, nor is it a preventative form of *medicine*. Medically-based care specializes in the *diagnosis* and *treatment* of specific symptoms, illness and disease. Our function-based chiropractic care specializes solely in helping people of all ages ensure that their spines and nerve systems are functioning as optimally as possible. This in turn allows their bodies to work the best they possibly can.

So while the natural result of optimal function *is* increased **health**, **wellness** and an **overall improved quality of life**, we will not diagnose, treat or attempt to cure any specific physical, mental or emotional ailment, nor will we give advice about specific medical conditions or treatments.

If you are seeking care for the removal of a *specific* medical symptom or condition, we suggest you seek additional help from a symptom, illness, and disease orientated professional if you feel that our function-based approach will not be sufficient in progressively raising you to the levels of health, wellness and quality of life you desire for yourself and your family.

I, _____, have read and understand the above statement and I hereby give permission for Dr. Tye Moe to continue with my child's and/or my initial consultation and assessment. I also agree to return at a later date to allow Dr. Moe to report his findings and recommendations to me. By agreeing to this, I am in no way obligated to follow the advice given to me in the report of findings.

Signed_____ Date ____/____/____

We sincerely thank you for choosing our center and for taking the time to honestly reflect upon and share your current level of health and well being, as well as your goals.

We look forward to helping you maximize your experience and expression of health and life!