CHILD HEALTH PROFILE & PERMISSION - Completed by Parent

Initial Visit Date: _____/_____/_____

Name of Parent: _____ Name of Child: _____

Address: _____

City/State/Zip: _____

Work #: _____ Home #: _____ Cell #: _____

Date of Child's Birth: _____/_____/_____ Child's Age: _____ Child's Gender: Male / Female

How did you hear about our office? _____

Has your child ever received Spinal Adjustments or Network Spinal Analysis Entrainments by a Doctor of Chiropractic before? YES NO If yes, when and by whom? _____ Total time receiving care?____

Have you or your spouse ever received Chiropractic care? YES NO Network Care? YES NO

What other natural forms of healthcare has your child received? _____

What do you hope for your child to receive from Chiropractic care in this office? _____

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR CHILD'S HEALTH HISTORY

Were you physically ill prior to or during the pregnancy? YES NO _____

Was the pregnancy difficult? YES NO _____

Did you have any falls, accidents or physical injuries during the pregnancy? YES NO _____

Was your labor chemically induced? YES NO _____

Were you conscious / semiconscious / unconscious? _____

Was the birth: ____drug induced ___forceps or suction ___C-section ___breech

___natural ___prolonged ____cord around the neck

Was the birth: __at home ___in a birthing center ___in a hospital ___other _____

Was your child incubated or isolated? YES NO _____

Was your child: __bottle fed __breast fed __other _____

Has your child experienced any of the following? (If so please list when and any further comments you wish to share):

__Headaches __Allergies __Ear infections __Breathing problems __Fatigue __Irritability

__Hyperactivity __Flu __Frequent colds __Bloody noses __Meningitis __Diarrhea __Colic

___Constipation ___Rashes ___Milk or Lactose Intolerance ___Bed Wetting ___Asthma
___ADD/ADHD ___Sleeping Disorders ___Digestive Problems ___Others _____

Has your child ever been unconscious? Yes No _____

Has your child ever used crutches or corrective braces? Yes No _____

Is your child accident-prone? Yes No _____

Has your child had any major falls? Yes No _____

Has your child ever been involved in an auto accident? Yes No _____

Has your child ever been hospitalized or had surgery? Yes No _____

Has your child ever had any broken bones or sprain injuries? Yes No _____

Is you child currently on any medications? Yes No _____

Please list medications: _____

Has your child been vaccinated? Yes No _____

Is your child active in any sports? Yes No If yes, which ones? _____

Is your child hyperactive? Yes No _____

Does your child have learning disorders? Yes No _____

Does your child have poor posture? Yes No _____

Is your child nervous, or has anyone suggested that your child was nervous? Yes No _____

How would you rate your child's physical health?

___excellent ___good ___fair ___poor ___getting better ____getting worse

How would you rate your child's emotional/mental health?

___excellent ___good ___fair ___poor ___getting better ____getting worse

Is there anything else you wish to share which may help us to better understand your child?

_____

I hereby authorize Dr. Ginni Gross, D.C., at Touch Light Chiropractic, and whomever she may designate, to administer care necessary to my child named above.

Parent/Guardian's Name: _____

Parent/Guardian's Signature : _____ **Witness:** _____

Date: _____