

BODY OF LIGHT FAMILY CHIROPRACTIC
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Welcome to our office. We are honored and blessed that you have chosen our office to serve your family. Please know that we will care for your children with the greatest respect and tenderness.

Pre-school Child History
3-5 years

Child's Name _____ Birthdate _____ Sex: M F

Address _____ City _____ Zip _____

Parents' Names _____

Parent's Phone _____ Work# _____

Siblings and ages _____

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

CAUSE

The human body is designed to be healthy. The primary system in the body that coordinates health is the nervous system. The healthy function of every cell, every system and every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system.

From the birth process until the present, events have occurred in your child's life that may have caused interference and damage to this delicate system. Physical, emotional and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex (VSC).

This form will help reveal the causes of Vertebral Subluxation that interfere with the optimal function of your child's nervous system and therefore impair your child's inborn health and well-being.

REASON FOR TODAY'S VISIT: _____

Does your child complain of pain or discomfort? Yes No If yes, when did this occur? _____

Was the onset: ___ Sudden ___ Gradual Is the problem: ___ Constant ___ Intermittent

Has your child ever had this problem before? Yes No _____

Has your child previously been treated for this problem? Yes No By whom? _____

Has your child previously had chiropractic care? Yes No By whom? _____

The power that made the body heals the body

NUTRITION

Do you have any concerns about your child's diet? Yes No _____

Does your child have any food allergies? Yes No _____

Does your child have any persistent or intermittent skin rashes? Yes No _____

Does your child take vitamin supplements? Yes No _____

Does your child eliminate stools each day? Yes No _____

Does your child have any digestive disturbances? Yes No _____

For how long was your child breast-fed? _____

What does your child usually eat for breakfast? _____

What does your child usually eat for lunch? _____

What does your child usually eat for dinner? _____

What does your child usually eat for snacks? _____

What type, and how often does your child eat fast food? _____

How much cow's milk does your child drink/day? _____

TRAUMA

Place of birth: ___ Home ___ Birthing Center ___ Hospital

Provider: ___ Midwife ___ OB-Gyn. Other _____

Type of Birth: ___ Vaginal ___ C-section ___ emergency ___ scheduled

Was the birth: ___ Doctor assisted ___ Forceps Other _____
 ___ Vacuum Extraction ___ Twisting/Pulling

Was your child breech? Yes No _____

Was there any trauma to your newborn? Yes No _____

If yes, please describe medical procedures and tests: _____

Has your child had any recent falls or trauma? Yes No _____

Describe the trauma and the date it occurred: _____

Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar? Yes No _____

Has your child ever fallen down stairs or fallen from any height? Yes No _____

Has your child ever been in a motor vehicle collision or near miss? Yes No _____

Has your child had any other trauma or injuries? Yes No _____

Has your child ever had a bone fracture/dislocation Yes No _____

HEALTH HISTORY

Does your child ever complain of back or neck pain? Yes No _____

Does your child ever complain of pains in the arms and legs? Yes No _____

Does your child ever complain of headaches? Yes No _____

Has your child had asthma? Yes No _____

Is your child allergic to anything? Yes No _____

Are there any smokers in the child's home? Yes No _____

Has your child had any earaches? Yes No At what age did the first earache occur? ____

How frequently does your child have earaches? _____

How many courses of antibiotics has your child been exposed to? _____

Has your child had any other illnesses? Yes No _____

Is your child presently receiving any medications? Yes No _____

Has your child ever been to a hospital or emergency room for evaluation or treatment? Yes No _____

Has your child recently been vaccinated? Yes No _____

Do you have any other concerns about your child's health? Yes No _____

QUALITY OF LIFE AND CURRENT HEALTH STATUS

How do you grade your child's physical health?	Excellent	Good	Fair	Poor
How do you grade your child's emotional/mental health?	Excellent	Good	Fair	Poor
How do you grade your child's overall "quality of life"?	Excellent	Good	Fair	Poor

Do you believe your child is expressing their full health potential? Yes No If no, why? _____

How can we/chiropractic help your child achieve their optimum health? _____

CORRECTION

Today, we are becoming more aware how current technological lifestyles and practices expose our children's nervous systems to continuous stresses. These result in Vertebral Subluxations.

Current scientific research is showing the direct relationship between the function of the nervous system and the immune system. The integrity of the nerve system is therefore imperative to a healthy immune system in your growing child.

Today, your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic, the only health care provider qualified to locate, analyze and correct the Vertebral Subluxation Complex. Correction of the Subluxation with the Chiropractic Adjustment is the beginning of greater health and well-being for your child.

AUTHORIZATION TO EXAMINE/PROVIDE CARE TO A MINOR

I hereby Authorize Drs. Spear to perform a chiropractic evaluation, and provide chiropractic care if needed, to my child.

Signed _____ Date _____

Witnessed _____ Date _____

AUTHORIZATION TO TAKE AND PUBLISH PHOTOGRAPHS

I, _____, authorize Body of Light Family Chiropractic to take and publish photographs of my child, _____, for clinical records. Such photographs may be used in publications for the purpose of scientific and /or clinical research, chiropractic education, and the promotion of chiropractic health care when the above named Doctor deems such publication will benefit these goals. I also understand I will not be identified by name without additional authorization.

DATE: _____

SIGNED: _____

WITNESS: _____

**Thank you for choosing Body of Light Family Chiropractic.
We know there is no more precious gift than your children.**