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.

INFANT HISTORY
2 months to 2 years

Child's Name_____Birthdate_____ Sex:_____

Address_____City_____Zip_____

Parents' Names_____

Parent's Phone_____Work#_____

Parent's Employer_____

Siblings:_____

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? _____

NUTRITION

Is your child still being breast fed? Yes No If no, how long were they breast-fed? _____

Is your child formula fed? Yes No If yes, which formula or milk source? _____

Is your child eating solid food? Yes No If yes, which foods?

_____

Does your child have any feeding difficulties? Yes No _____

Does your child have any digestive disturbances? Yes No _____

Does your child have any food allergies? Yes No _____

Does your child have any skin rashes? Yes No _____

Is your child receiving any vitamin supplements? Yes No _____

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

___ Vacuum Extraction ___ Twisting/Pulling Other_____

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 If yes, please describe:

_____

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 _____

Does your child ever bang his/her head repeatedly against a wall, bed or other object? Yes No _____

GROWTH AND DEVELOPMENT

Can your child sit unsupported? Yes No If yes, at what age did they start? _____

Is your child crawling yet? Yes No If yes, at what age did they start? _____

Is your child walking yet? Yes No If yes, at what age did they start? _____

Does your child often trip and fall? Yes No _____

Do you have any other concerns about your child's growth and development? Yes No _____

HEALTH HISTORY

Has your child had colic? Yes No _____

Has your child had any upper respiratory infections? How often? Yes No _____

Has your child had asthma? Yes No _____

Does your child ever complain of arm/leg pain? Yes No _____

Does your child ever complain of headaches? Yes No _____

Has your child had any earaches? Yes No If yes, at what age did they begin? _____

How frequently does your child have earaches? _____ How many courses of antibiotics? _____

Has your child had any other illnesses? Yes No If yes, please describe:

_____

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 BILL INSURANCE/FINANCIAL POLICIES:

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I also understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

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.

I also acknowledge that I have read through and agree to the financial policies and publishing of photographs/testimonials as described above.

Parent/Guardian: _____ _____
Print name Signature

Child's name: _____ _____
Date

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