BODY OF LIGHT FAMILY CHIROPRACTIC
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Children's Case History Ages 6+

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? _____

CHIROPRACTIC

Has your child had their vision checked by an optometrist? Yes No
Has your child had their teeth checked by a dentist? Yes No
Has your child had their spine and nervous system checked by a chiropractor? Yes No

If yes, who was the chiropractor, when were they last seen, and what was the original reason for being checked?
_____

Were x-rays taken? Yes No If yes, when were they taken: _____

NUTRITION

Did you breast-feed your child? Yes No If yes, for how long? _____

How would you rate your child's diet? Excellent Good Fair Poor

How many servings of fruits and vegetables per day? _____

Does your child consume: ___ Sodas ___ Processed foods ___ High sugar foods (cereal/donuts)
___ Sweetners ___ Fast food ___ Simple Carbs (bagels, white bread)

Other/explain: _____

TRAUMA

Place of birth: ___ Home ___ Birthing Center ___ Hospital.
Provider: ___ Midwife ___ OB-Gyn. ___ emergency ___ scheduled
Type of Birth: ___ Vaginal ___ C-section Other _____

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

Newborn trauma (medical procedures and tests)_____

Did you vaccinate your child? Yes No
If yes, were there any adverse reactions? _____

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 _____

Has your child had any surgeries? Yes No _____

Which sports does your child play?

___ Soccer ___ Football ___ Gymnastics ___ Hockey ___ Lacrosse
___ Dance ___ Wrestling ___ Baseball ___ Karate ___ Basketball

Other_____

Other than sitting in the classroom, does your child spend additional prolonged time sitting? Yes No Is it in front of a computer or TV? _____

How would you rate your child's posture? Excellent Good Fair Poor

Please explain what you observe about their posture (slouch, forward head etc.):

_____

Health History:

Has your child suffered from any of the following?

___ Colic	___ Headaches	___ Digestive problems	___ Irregular Sleeping Patterns
___ Ear Infections	___ Seizures	___ Bed Wetting	___ Learning Disorders
___ Allergies	___ Tantrums	___ Chronic colds	___ Emotional Disorders
___ Asthma	___ Night Terrors	___ Chronic Infections	___ ADD or ADHD

Other:

_____

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

Does your child ever complain arm/leg pain? 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? _____

Is your child presently receiving any medications? Yes No _____

Has your child ever been to a hospital or ER? 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.

The power that made the body heals the body

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 are honored and blessed
that you have allowed us the pleasure of serving your family.
We know there is no more precious gift than your children.