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FLOWER OF LIFE
CHIROPRACTIC

PED NEW MEMBER HEALTH SURVEY

Child's Name_____ Sex: ❑ M ❑ F DOB____/____/____ Age____

Parent's Name _____

Address_____ City_____ State_____ zip _____

E-mail_____@_____.com Phone_____

Sibling's Name & Age(s)_____

How did you find our office? _____

Your genes are not your destiny; your environment determines what genes are turned on and how they express. Your biography becomes your biology.

We are going to ask you a variety of questions that give us more information about your child's past and present experiences. These experiences affect your child's physiology and directly affect their physical, mental, emotional and spiritual wellbeing. These experiences fall into three categories; physical (trauma), mental/emotional/spiritual (thoughts) and chemical (toxins). If this experience was too much for your system to handle it locks down as a tonal shift (tension) which can lead to a variety of symptoms. Please fill the form out to the best of your ability. Your health survey is a key to the puzzle. No detail is too small.

CHILDS HISTORY - *Your story starts with your conception, gestation and most importantly, your birth. The birth process can be very stressful on mom but also on baby.*

Was this birth planned? ❑ Y ❑ N Were fertility measures taken? _____

Did mom use any of the following during pregnancy: ❑ Tobacco ❑ Alcohol ❑ Medications _____ ❑ Drugs

Did any occur during pregnancy: ❑ Falls or Injuries ❑ Abuse (physical, sexual, emotional) ❑ Complications

Please describe your stress level during this pregnancy _____

CHILD'S BIRTH HISTORY

Where did you give birth: _____ Provider: _____

At What Week of Pregnancy Was Your Baby Born?_____ Doula? _____

Were you happy with your birth providers? ❑ Y ❑ N _____

Baby's Position at time of Delivery: ❑ Head Down ❑ Posterior ❑ Facial ❑ Brow ❑ Breech

Birthing Position: ❑ On Back with Feet up ❑ On Side ❑ Squatting ❑ Kneeling ❑ Other: _____

Was baby's birth: ❑ Vaginal without assistance ❑ Vaginal with Assistance (❑ Forceps ❑ Vacuum Extraction)

❑ C- Section ❑ Induced labor prior to natural contractions ❑ Acupuncture Induced ❑ Cytotec ❑ Epidural

❑ Ruptured Membranes ❑ Pain Medications or Anesthesia ❑ Antibiotics ❑ Episiotomy/tear ❑ Ptocin

How Long was Labor? _____ How long was delivery (pushing)? _____

Baby's APGAR Scores: _____ Any Visible Injury to Baby? ❑ Y ❑ N _____

Did you: Do Skin to Skin ❑ Y ❑ N (how soon after) _____ Vaginal Swab ❑ Y ❑ N

Delay Cord Clamping ❑ Y ❑ N (how long) _____ Uninterrupted family time ❑ Y ❑ N (how long)_____

Was baby separated ❑ Y ❑ N (how long) _____ Did baby latch right away? ❑ Y ❑ N (how long) _____

Was baby circumcised? ❑ Y ❑ N when? _____ Bathed ❑ Y ❑ N (when) _____

Any evidence of trauma during birth: ❑ Bruises ❑ Odd shaped head ❑stuck in birth canal ❑ fast and/or Excessively long birth

❑ Respiratory Depression ❑ Cord around neck ❑ other _____

Complications during birth _____

APGAR at Birth_____ APGAR after 5 min _____ Birth Weight _____ Birth Length _____

The birth was…_____

PHYSICAL STRESSORS (other)

Any Lip or Tongue Tie: ❑ Y ❑ N Who did revision & When? _____

Surgery (& year performed) : _____

Accidents: _____

Falls: _____

Sports (past & present): _____

Gait: ❑ Toe Walking ❑ Bow legged ❑ Turned in ❑Scooting ❑ Army Crawl ❑ Hip Dysplasia ❑ Club Foot

Sensory: ❑ Sensory seeking ❑ Sensitive to Stimuli ❑ Attentive to only some stimuli _____ ❑ Side preference __

PSYCHOLOGICAL STRESSORS

Any difficulties with nursing? ❑ Y ❑ N _____ Any problems bonding? ❑ Y ❑ N _____

Was your child breast fed? ❑ Y ❑ N How Long? _____ Pain / Clicking / Breast refusal

Does your child feed: ❑ On both sides equally ❑ On Schedule ❑ On Demand

Does your child have any behavioral problems? ❑ Y ❑ N _____

Does your child have difficulty sleeping/ night terrors/ bed wetting? ❑ Y ❑ N _____

Bowel movements: _____ X per day Consistency_____ Recent Changes _____

How has/was Mom's healing postpartum? _____

How long is/was Maternity Leave? _____ Do/Did you have assistance with baby? ❑ Y ❑ N

CHEMICAL STRESSORS- *Anything inhaled, ingested or absorbed*

Formula: ☐ Y ❑ N Brand: _____ How much: _____

When was the introduction of food? _____ What were first foods? _____

Medications (type & reason): _____

Allergies? ❑Y ❑ N Please list with reaction _____

Vaccine History: ❑ Full CDC ❑ Selective schedule ❑ Delayed schedule ❑ None

Reaction to Vaccine ❑ Y ❑ N (please explain)_____

CURRENT HEALTH CONCERNS

What is the reason for this reservation?_____

When did this begin?_____ Have they had this before? _____

Why do you think this is occurring?_____

Is there any other issue/secondary condition that you believe is related to this?_____

Have you gotten any other advice or treatment for this issue? (if yes than from who and what was result)

_____

What activities aggravate your condition? _____

What activities relieve your condition? _____

Is the condition worse during certain times of the day? ❑ Y ❑ N If yes, when? _____

Concerns with Menstrual Cycle? ❑ Y ❑N _____

Does it affect: ❑ Mood, patience, attitude ❑ Sleep ❑ exercise or play ❑ day-to-day activities ❑ Ability to work
❑ decision making ❑ relationship or intimacy

Have you been to a chiropractor? ❑ Y ❑ N Has your child been to a chiropractor before? ❑ Y ❑ N

What are your healthcare goals? _____

DEVELOPMENTAL MILESTONES-

Age	Milestone	Not Met	Met	Delayed by	Age	Milestone	Not Met	Met	Delayed by
1 Month	Fist Clench	☐	☐		8 Months	Sits Unaided	☐	☐	
2 Months	Smiles	☐	☐			Plays with Hands	☐	☐	
	Hands Open	☐	☐			2 Syllable word "dada"	☐	☐	
	Cooing	☐	☐		9 Months	Pulls to Stand	☐	☐	
3 Months	Head Control	☐	☐			Shows Joy/ Displeasure	☐	☐	
	Opens Mouth	☐	☐		12 Months	Crawling	☐	☐	
4 Months	Laughs	☐	☐			Pull to stand	☐	☐	
	Looks at object in hand	☐	☐			Walk with support	☐	☐	
5 Months	Back to Stomach	☐	☐			Finger Feeds	☐	☐	
6 Months	Sits Alone	☐	☐		15 Months	Walks Alone	☐	☐	
	1 Syllable word "da"	☐	☐			Says 4-5 Words	☐	☐	
	Reaches	☐	☐			Indicates Wants	☐	☐	
	Roll Over	☐	☐			Names objects	☐	☐	

SECONDARY CONDITIONS- *Please mark any secondary condition (symptom/diagnosis) that you currently have or have had in the past. Secondary conditions are a result of your body compensating or adapting to your environment.*

Past	Now		Past	Now	
☐	☐	ADD/ADHD	☐	☐	Hand/Wrist Concerns
☐	☐	Asthma/ Respiratory Issues	☐	☐	Headaches
☐	☐	Athletic Injuries	☐	☐	Growing Pains
☐	☐	Autism Spectrum	☐	☐	Learning Difficulties
☐	☐	Bed Wetting	☐	☐	Insomnia
☐	☐	Behavior Issues	☐	☐	Knee/Hip Issues
☐	☐	Bowel/Bladder Changes	☐	☐	Plagiocephaly
☐	☐	Broken Bone	☐	☐	Neck Pain
☐	☐	Cancer	☐	☐	Reflux
☐	☐	Colic	☐	☐	Scoliosis
☐	☐	Concussion/ Head Injury	☐	☐	Seizures
☐	☐	Dental/Jaw issues	☐	☐	Skin Conditions
☐	☐	Depression	☐	☐	Sinus Problem/ Allergies
☐	☐	Digestive Issues	☐	☐	Surgery
☐	☐	Dizziness/Vertigo	☐	☐	Tongue/ Lip Tie
☐	☐	Ear Infections	☐	☐	Thyroid Disorder
☐	☐	Eye/Vision Issues	☐	☐	Weight Changes
☐	☐	Frequent Cold/Flu	☐	☐	Other _____

YOUR CHILD'S HEALTHCARE TEAM (PRIMARY CARE, THERAPISTS, SPECIALISTS ECT)

Provider Name	Provider Type	Last Visit	Reason	Result

Patient Signature _____ Date _____

Entered into Computer _____ initial _____

PEDIATRIC ASSESSMENT

Name_____ Asmt #_____ Date___/____/___ Age ____Cat_____ Score_____%

Structural Assessment: ____

Category: 1 (-2) **2** (-7) **3** (-10) ____

Atlas-head rotate away from side of lateral atlas.

(hip joint bogginess on same side of lesion→ occiput on the look away side)

Pediatric Tests:		**Expected Integration**
Acousticblink	+ -	
Ortolani'sReduction	+ -	
Moro	+ -	2-4Mo(flex&extensionoflimbs)
Placing(0-6w)	+ -	BeforeWalking
Sucking(0-4m)	+ -	0-4moths
Parachute(6m-1yr)	+ -	Absentuntil6-10mo
Neckrighting	+ -	0-4M
ATNR	+ -	2w-4m (turn head L&R—> arm ex on face side)
Lightresponse	+ -	
STNR	+ -	5-6m Prone = Limb flexion,supine=limb extension

____

Primitive Reflexes:	**L**	**R**	**Expected Integration**
Rooting	+ -	+ -	3-4M
Palmar	+ -	+ -	3M
Plantar	+ -	+ -	8M
Galant	+ -	+ -	3-9M
Babinski	+ -	+ -	12M

Leg Length: L R 0 ⅛ ¼ ½ ¾ ____

Heel tension: L: N D I R: N D I ____

Sacrum: L R Mild Moderate (0,5,7,10) ____

Sacral Dural Pump: O:P L A S: P L A ____

Disconnections:_____ (-1 per) ____

Muscular/Ligamentous Patterns: 1 2 3 4 5 6 (3,7,10) ____

Osseous Subluxations_____(-2foreach) ____

Cranium: Occiput: L R **Frontal**: L R **Parietal:** L R **Temporal:** L R **Sphenoid:** L R ____

Sutures: Sagittal Coronal Occipital Parietal Lambdoidal ____

Psoas: R L **Occipital Fiber:** 1 2 3 4 5 6 **Dollar Crest**

Doctor: Dr. Erin Dr. James Dr. Jamie Dr. Laura Dr. Justyna ____/____

Notes:

_____

_____

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- FOR OFFICE USE ONLY -