



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

Birth 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 Ptoicin

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"			
3 Months	Cooing				9 Months	Pulls to Stand			
	Head Control					Shows Joy/ Displeasure			
4 Months	Opens Mouth				12 Months	Crawling			
	Laughs					Pull to stand			
5 Months	Looks at object in hand					Walk with support			
	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

- ADD/ADHD
- Asthma/ Respiratory Issues
- Athletic Injuries
- Autism Spectrum
- Bed Wetting
- Behavior Issues
- Bowel/Bladder Changes
- Broken Bone
- Cancer
- Colic
- Concussion/ Head Injury
- Dental/Jaw issues
- Depression
- Digestive Issues
- Dizziness/Vertigo
- Ear Infections
- Eye/Vision Issues
- Frequent Cold/Flu

Past Now

- Hand/Wrist Concerns
- Headaches
- Growing Pains
- Learning Difficulties
- Insomnia
- Knee/Hip Issues
- Plagiocephaly
- Neck Pain
- Reflux
- Scoliosis
- Seizures
- Skin Conditions
- Sinus Problem/ Allergies
- Surgery
- Tongue/ Lip Tie
- Thyroid Disorder
- Weight Changes
- 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 _____ %

Structure: _____

ROM: _____

- C: Flexion:50 (N M Mo S) (D S R)
- Extension:60 (N M Mo S) (D S R)
- L Rotation:80 (N M Mo S) (D S R)
- R Rotation:80 (N M Mo S) (D S R)
- L Lateral:45 (N M Mo S) (D S R)
- R Lateral:45 (N M Mo S) (D S R)
- L: Flexion: 25 (N M Mo S) (D S R)
- Extension: 30 (N M Mo S) (D S R)

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)

Fakuta: - Ft forward (-1) _____ Shift (-1) L R Turn (-3) L R _____

Pediatric Tests:

Expected Integration

- Acoustic blink + -
- Ortolani's Reduction + -
- Moro + - 2-4 Mo (flex & extension of limbs)
- Placing(0-6w) + - Before Walking
- Sucking(0-4m) + - 0-4 moths
- Parachute (6m-1yr) + - Absent until 6-10 mo
- Neck righting + - 0-4 M
- ATNR + - 2 w - 4 m (turn head L & R→ arm ex on face side)
- Light response + -
- STNR + -

5-6 m Prone= Limb flexion, supine= limb extension

Primitive Reflexes:

L R

Expected Integration

- Rooting + - + - **3-4 M**
- Palmar + - + - **3 M**
- Plantar + - + - **8 M**
- Galant + - + - **3-9 M**
- Babinski + - + - **12 M**

Leg Length: L R 0 1/8 1/4 1/2 3/4

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

Sacrum: L R Mild Moderate

Sacral Dural Pump: O: P L A S: P L A (0,5,7,10)

Disconnections: _____ (-1 per)

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

Osseous Subluxations _____ (-2 for each)

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

Sutures: Sagittal Coronal Occipital Parietal Lambdoidal

Doctor: Dr. Erin Dr. James Dr. Jamie Dr. Laura Dr. Madi

Notes:

----- TO BE COMPLETED BY DOCTOR -----