



2055 Third Ave., Suite B, San Diego, CA 92101 • (619) 239-0053 • www.warrenfamilywellness.com

CHILDREN'S HEALTH PROFILE

Please answer all questions as completely as possible

CHILD'S NAME _____ DATE _____

ADDRESS _____ CITY/STATE/ZIP _____

HOME PHONE _____

BIRTHDATE _____ AGE _____ GENDER: M F HEIGHT _____ WEIGHT _____

PARENT'S NAME _____ SIBLINGS' NAME _____

PARENT'S OCCUPATION _____ EMPLOYER _____

WORK PHONE _____ EMAIL _____

HOW DID YOU HEAR ABOUT OUR WELLNESS CENTER? _____

DO YOU CURRENTLY HAVE ANY HEALTH CONCERNS FOR YOUR CHILD? _____

WHEN DID THIS SITUATION OR CONCERN BEGIN? _____

HAS THIS SITUATION OR CONCERN HAPPENED BEFORE? Yes No

Please explain: _____

HAVE YOU SEEN OTHER DOCTORS FOR IT? Yes No

Doctor's name(s) _____

Type(s) of treatment _____ Results _____

HAS THIS SITUATION OR CONCERN: _____ gotten worse _____ stayed constant _____ comes and goes

DOES IT INTERFERE WITH: _____ sleep _____ school _____ play _____ social functioning _____ other activities

Please explain: _____

PRENATAL & BIRTH HISTORY

During the pregnancy, did the mother:

• experience any falls or physical traumas? Yes No

Explain: _____

• experience any illness? Yes No

Explain: _____

• take any medications? Yes No

List: _____

• smoke or consume alcohol? Yes No

Where did the birth take place?

_____ hospital _____ birthing center _____ home _____ other

Was the delivery premature? Yes No

If yes, at _____ months and _____ weight

Approximately how long did labor last? _____ hours

Was labor chemically induced? Yes No

Was labor doctor assisted? Yes No

Was a C-section performed? Yes No

Was forceps or vacuum extraction used? Yes No

Did the delivery doctor pull or twist the baby during delivery? Yes No

Were any genetic disorders or disabilities detected?

Yes No Explain: _____

Check any of the following that the child may have experienced immediately after birth:

_____ jaundice _____ respiratory problems

_____ feeding problems _____ displaced or broken joints

_____ other condition(s): _____

Birth weight: _____ Birth length: _____

APGAR scores: _____ , _____

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has had in the past or has now:

- Vision problems
- Headaches
- Sleeping disorders
- Irritability
- Skin problems
- Allergies
- Breathing problems
- Asthma
- Hyperactivity
- Constipation
- Bed wetting
- Pink Eye
- Ear infections
- Tubes in the ears
- Attention problems
- Frequent colds
- Colic
- Digestive problems
- Other: _____
- Comments: _____

Was your child breast-fed? Yes No For _____ months

Has your child:

- been hospitalized? Yes No
- been seen on a Emergency basis? Yes No
- had any surgeries? Yes No
- been in a car accident? Yes No
- had a severe fall? Yes No
- been injured in any high impact or contact type sports (soccer, football, baseball, gymnastics, cheerleading, martial arts, etc.)? Yes No

Explain: _____

CHILD'S CURRENT HEALTH STATUS

What changes (if any) in your child's health and/or behavior have you seen that might have you concerned?

How often does your child "get sick"?

About _____ times/year

For how long usually? About _____ days

How would you grade the severity of these episodes?

Mild = 1 2 3 4 5 = Severe

Has your child ever taken antibiotics? Yes No

Please explain: _____

Is your child currently taking any medication? Yes No

Please explain: _____

Does your child have any allergies to any foods, medications, environmental factors, etc.? Yes No

Please explain: _____

VACCINATION HISTORY

Have you chosen to vaccinate your child? Yes No

If yes, check all vaccinations your child has received:

____ Hepatitis B ____ DPT ____ Polio ____ MMR

____ Chicken Pox ____ Other: _____

Describe any and all reactions to vaccine(s): _____

What changes (if any) in your child's health and/or behavior would you like to see? _____

Is there anything else you would like to share about your child or family which will help us to better understand you and why you have chosen us to assist your child in his/her healing? _____

AUTHORIZATION OF CARE FOR A MINOR CHILD

I, _____ being the parent or legal guardian of _____ have read and fully understand the Statement of Clinical Objectives and hereby grant permission for my child to receive Chiropractic care.

Patient's Name (print)

Parent/Legal Guardian's Name (print)

Parent/Guardian's Signature Authorizing Care

Date

Thank you for choosing our Wellness Center for your family's chiropractic care. We look forward to helping your family increase its ability to develop a healthy spine and nervous system.