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Pediatric
School Aged Children



Practice Member Information

File _____

Child's Name: _____ M _____ D _____ Y _____
Parent's/Guardian's Names: _____
Home Address: _____
City _____ State _____ Zip _____
Home Phone: _____ May we leave a message? Yes No
Parent's Cell Phone: _____ May we leave a message? Yes No
Parent's Work Phone: _____ May we leave a message? Yes No
Parent's Email: _____
May we add you to our email newsletter and calendar of events? Yes No (Your email will not be shared)
How did you hear about us? _____
Height (of child): _____ Weight (of child): _____ Birth Date: M _____ D _____ Y _____ Age: _____ Sex: M F
Siblings and ages: _____
Previous Chiropractic Care? Yes No

Emergency Contact

Name: _____ Relationship to child: _____
Phone number: _____ Alternate phone number: _____

Family Doctor

Name: _____ Professional Designation: _____
Clinic Name: _____ Date and reason of last visit: _____
May we communicate with your family doctor regarding your child's care if necessary? Yes No

Other Health Care Professionals

(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, Massage Therapist, etc)

Name: _____
Professional Designation: _____
Date and reason of last visit: _____

Name: _____
Professional Designation: _____
Date and reason of last visit: _____

Why have you decided to have your child evaluated by a Chiropractor?

He/She is continuing ongoing care from another chiropractor.
I recently had my spine checked and understand the value in getting my child checked.
I have concerns about his/her health and I'm looking for answers.
He/She has a specific condition and I've learned that chiropractic may be able to help.
I want to improve my child's immune function.



The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called **vertebrae**. Many of the common health challenges that adults experience have their origins during the **developmental years**, some starting at birth. Layers of damage to the spine and **nervous system** occur as a result of various **traumas, toxins and emotional stress**. The result may be misalignment to the spinal column and damage to the nervous system in a condition called **Vertebral Subluxation**. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's **ability to heal**.

CURRENT	PREVIOUS	CURRENT	PREVIOUS	CURRENT	PREVIOUS
	Asthma		Frequent Diarrhea		Failure to Thrive / Slow Weight Gain
	Respiratory Tract Infections		Constipation		Slow or Absent Reflexes
	Sinus Problems		Flatulence		Asymmetrical Crawling or Gait
	Ear Infections		Headaches/Migraines		Weight Challenges
	Tonsillitis		Neck Pain		Bed Wetting
	Strep Throat		Torticollis / Head Tilt		Sleep Problems
	Frequent Colds / Croup		Trouble Feeding on One Side		Night Terrors
	Recurrent Fevers		Back Pain		Tip Toe Walking
	Eczema		Growing Pains		Regression of Milestones
	Rashes		Scoliosis		Seizures
	Allergies		Red, Swollen, Painful Joint		Tremors / Shaking
	Food Sensitivites		Colic		ADD / ADHD
	Digestive Problems		Frequent Crying Spells		Autism / PDD

Has your child had x-rays in relation to the current complaint? . . . No Yes

Exposure to alcohol, cigarettes or second hand smoke during pregnancy: No Yes

Birth Experience

Location of Birth: Home Hospital Birthing Centre Other _____
 Birth Attendants: Doula Midwife GP OB Other _____
 Medications during labor / delivery (including IV antibiotics) No Yes _____
 Was Pitocin used to induce / speed up labor? No Yes _____
 Were your membranes ruptured by a medical professional? No Yes _____
 Was your child at anytime during your pregnancy in an intra-uterine constraining position? No Yes Unsure
 If yes, please describe: Breech Transverse Face / Brow presentation _____
 Was your delivery vaginal or C-section? _____ If it was a C-section, was it planned or emergency? _____
 If it was vaginal, was the baby presented: Head Face Breech _____
 Were any of the following interventions used during delivery? Forceps Vacuum Extraction Other _____
 Were there any complications during delivery? Yes No _____
 If yes, please specify: _____
 How long was the labor from the first regular contractions to the birth? _____ Hours
 How long was the second stage (the pushing phase) of the labor? _____ Hours
 Was the baby born with any purple markings / bruising on their face or head? No Yes _____
 Any concerns about misshapen head at birth? No Yes _____

Post Natal & Infant History

How many weeks gestation was the baby at birth? ____w ____d / Birth Weight: ____lbs ____oz / Birth Length: ____Inches
 If known, APGAR scores at: 1 minute ____/10 5 minutes ____/10
 Was the baby ever administered to Neonatal Intensive Care? No Yes _____
 If yes, for how long and why? _____
 Was any medication given to the baby at birth? Yes No Unsure _____
 If yes, what medication and why? _____
 Was your child exclusively breastfed? No Yes ____ months
 Was your child breastfed + formula fed? No Yes ____ months
 Did your child show any sensitivities to formula (reflux, eczema, arching back, frequent spit up)? No Yes _____
 What age did you introduce solid foods to your child? ____ months
 Did you introduce cereal or grains within your child's first year? No Yes _____
 Did/Do you practice attachment parenting methods:
 (cosleeping, kangaroo care, elimination communication, feeding on demand, extended breastfeeding etc) No Yes _____
 Did your child spend excess time in any baby devices such as: bouncer seats, swings, bumbos, car seats etc?
 No Yes, Which ones? _____

Physical Traumas

Has your child ever fallen from any high places?	No	Yes	_____
Has your child ever been involved in a motor vehicle accident or near miss?	No	Yes	_____
Has your child been seen on an emergency basis?	No	Yes	_____
Has your child broken any bones?	No	Yes	_____
Has your child had any previous hospitalizations?	No	Yes	_____
Has your child had any previous surgeries?	No	Yes	_____
Does your child spend time using a tablet, computer or video games?	Never	Rarely	Daily Several hrs/day
Does your child watch tv?	Never	Rarely	Daily Several hrs/day
Does your child exercise?	No	Daily	Weekly Seasonally
Does your child play contact sports?	No	Daily	Weekly Seasonally
Does your child sleep on their	Back	Belly	Sides (Both, Right, Left)
Does your child carry a back pack?	No	Yes	
Does it weigh less than 15% of their body weight?	No	Yes	
Do they wear their back pack on 2 shoulders?	No	Yes	Sometimes
Does your child show excessive or uneven shoe wearing out?	No	Yes	
Does your child wear custom orthotics?			
No Yes, For what purpose? _____			

Chemical Stressors

Have you chosen to vaccinate your child? No Yes, on a delayed or selective schedule Yes, on schedule

Reason for vaccination: Informed decision Didn't know I had a choice It was recommended

Reaction(s) to vaccination: Fever Welp at injection site Rash Diarrhea Fatigue Prolonged Cry

Seizures Developmental Regression Other _____

Does your child receive annual flu shots? No Yes (informed decision) Yes (recommended by MD)

Has your child been exposed to antibiotics? No Yes

If yes, how many doses in past 6 months? _____ Reason _____

Were probiotics used at the same time as antibiotics? No Yes

Has your child been exposed to medications, including OTC: No Yes

If yes, which ones? _____

If yes, how many doses in past 6 months? _____ Reason _____

How many glasses of water/day does your child have? 0 1-3 4-6 7-9 10+

How many glasses of cow's milk, juice and soda/day does your child have: . . 0 1-3 4-6 7-9 10+

Does your child eat gluten? No Yes Trying to eliminate from diet

Does your child eat dairy? No Yes Trying to eliminate from diet

Does your child eat refined sugars (white sugar), white bread and pasta? . . No Yes Trying to eliminate from diet

Does your child eat boxed/frozen foods? No Yes Trying to eliminate from diet

Do you choose organic foods? No Yes If yes, which: Veggies Fruits Meats Grains All

Does your child eat any artificial sweeteners like Splenda, Aspartame, AminoSweet, Diet Soda? No Yes

Does your child follow any other dietary restrictions? No Yes _____

Any food/drink allergies, sensitivities, intolerances? No Yes _____

Is your child exposed to second hand smoke? No Yes _____

Does your child take a probiotic daily? No Yes: _____ CFU's/day

Does your child take vitamin D3 daily? No Yes: _____ IU's/day

Does your child take Omega 3 Fish Oils daily? No Yes: _____ mg/day Capsule Liquid

Other supplements or homeopathics? _____

Goals & Consent

Do you feel your child is developmentally appropriate for their age:

Intellectually: Yes No _____

Emotionally: Yes No _____

Physically: Yes No _____

What is your primary goal for your child at our clinic? _____

Our goals are to provide a detailed assessment of your child's current health status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You've taken an important step for your child's future through a chiropractic evaluation!

Consent to Evaluation of a Minor Child

I _____ being the parent or legal guardian of _____,
(print name of consenting adult) (print name of minor)

hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, examination and x-rays if warranted. Any findings will be communicated before consenting to commencement of care, if appropriate.

Consenting Adult's Signature _____

Date _____