The Body Well Chiropractic

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Welcome!

Your first visit to our center is an opportunity for us to learn all about you and your family. It is a time for you to share with us where you are now in your health and life, as well as what you would like to move toward. *And away we go!*

Personal Information - Pediatric

Name _____ Birth Date ____/____/____ Today's Date ____/____/____

Phone (H) _____ (W) _____ Ext. _____ (Cell) _____

Address _____
Number & Street City State Zip

Parent's Email Address _____

Mother's Name _____ Father's Name _____

Are parents ☐ Single ☐ Married/Partnered ☐ Widowed ☐ Divorced

# of Kids in family ____ How many at home? _____ Names & ages _____

_____

Has your child been to a chiropractor before? ☐ Yes ☐ No Approximate date of last visit ____/____/____

Dr.'s Name/City/State _____ Good results? ☐ Yes ☐ No

Is your child under care of any other doctor? Yes/No If Yes, the condition being treated for _____

_____

Whom may we thank for referring you to our center? _____

Your child's favorite hobbies or interests _____

Labor and Delivery History

Did you and/or your child experience any of the following during the labor/delivery

□ Hospital birth	□ Home birth	□ Birthing home	□ The labor was induced
□ Long and/or difficult labor	□ The delivery was rapid	□ Placenta previa	□ Forceps or suction cup used
□ Elective c-section	□ Emergency C-section	□ Fetal distress	□ Cord around the neck
□ The child was premature (2+ weeks)	□ The child was a "blue baby"	□ Breech birth	□ Other (explain)

Please list reasons for any interventions/complications during labor and delivery _____

_____

Rank mother's general stress level (0-10) during pregnancy _____

Did mother smoke during pregnancy? Yes/No

Any illness of mother during pregnancy? Yes/No If yes, please explain _____

List any drugs/medications (including over-the-counter) taken during pregnancy _____

_____

Let's Find Out Why You're Here…

Reason for seeking chiropractic care _____

_____

Any other specific concerns? _____

If seeking chiropractic for a specific concern, has your child been treated for this concern before? Yes/No

Please explain _____

When did this concern begin? _____

List all current medications and conditions being treated _____

_____

List any vitamins/herbs/homeopathics/other your child is taking _____

_____

Has child received any vaccinations? Yes/No If yes, list any reactions _____

_____

Has your child received any antibiotics? If yes, how many times and list reason _____

_____

List any past surgeries or hospitalizations and dates _____

_____

List any past accidents and dates _____

List any injuries _____

Has your child ever been under chiropractic maintenance care? _____

Date of your child's last adjustment (if applicable)_____

Do you know what a subluxation is? If yes, please describe _____

_____

Is/was your child breastfed? Yes/No If yes, how long? _____

Any difficulty with breastfeeding? Explain. _____

Is/was your child formula fed? Yes/No If yes, how long? _____

Any difficulty with bonding? Yes/No If yes, please explain _____

Any behavioral problems? Yes/No If yes, please explain _____

Does your child have regular bowel/bladder movements? Yes/No

Quality of Life Inventory

If your child has experienced any of the following, please indicate by writing **C** (Current), **P** (Past) or **CP** (Current and Past).

___ Fatigue
___ Diabetes
___ Fainting
___ Asthma
___ Anxiety
___ Cold Sweats
___ Weakness
___ Dizziness
___ Headaches
___ Migraines

___ Sinus problems
___ Frequent colds
___ Head injury
___ Serious illness
___ Meningitis
___ Heart problems
___ Loss of balance
___ Skin Conditions
___ Ulcers
___ Cancer

___ Digestion problems
___ Nervousness
___ Sleeping problems
___ Difficulty focusing
___ Seizures/Convulsions
___ Urinary problems
___ Mood swings
___ Low energy/tired
___ Allergies to foods
___ Environmental allergies

___ Chronic ear infections/earaches
___ Serious fall(s) or repetitive falls
___ Illnesses with a high fever
___ Trouble with bladder control
___ Joint or muscle problems
___ Nausea
___ Neck or back problems
___ Ringing in ears
Other_____

Let's Make Sure We're On the Same Page…

When an individual or family seeks and is accepted into a program of **function-based** chiropractic care, it is essential for all parties to be working toward the same objectives. We have only one goal, and it is important that everyone understands both our objective and the methods we will use to move consistently toward that objective.

Your care in our center is not a substitute or alternative for, nor is it a preventative form of *medicine*. Medically-based care specializes in the *diagnosis* and *treatment* of specific symptoms, illness and disease. Our function-based chiropractic care specializes solely in helping people of all ages ensure that their spines and nerve systems are functioning as optimally as possible. This in turn allows their bodies to work the best they possibly can.

So, while the natural result of optimal function *is* increased **health**, **wellness** and an **overall improved quality of life**, we will not treat or attempt to cure any specific physical, mental or emotional ailment, nor will we give advice about specific medical conditions or treatments.

If you are seeking care for the removal of a *specific* medical symptom or condition, we suggest you seek additional help from a symptom, illness, and disease orientated professional if you feel that our function-based approach will not be sufficient in progressively raising you to the levels of health, wellness and quality of life you desire for yourself and your family.

I, _____, have read and understand the above statement and I hereby give permission for Dr. Erin Torzewski to continue with my child's and/or my initial consultation and assessment. I also agree to return at a later date to allow Dr. Erin to report her findings and recommendations to me. By agreeing to this, I am in no way obligated to follow the advice given to me in the report of findings.

I also understand that The Body Well Chiropractic does not participate with third party insurance carriers. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Signed_____ Date ____/____/____

We sincerely thank you for choosing our center and for taking the time to honestly reflect upon and share your current level of health and well being, as well as your goals.

We look forward to helping you maximize your experience and expression of health and life!