



Welcome To Wellness!

36 Baboosic Lake Road
Merrimack, NH 03054
603*262*9200

Name _____ Age _____

D.O.B. _____ Address _____

City _____ State _____ Zip Code _____

Name(s) and age(s) of siblings _____

Parent(s)/Guardian (s) Name(s) _____

Parent(s)/Guardian(s) occupation(s) _____

Parent (s)/Guardian (s) Phone (Home) _____ (Work/Cell) _____

Who may we thank for referring you and your child to **Family Chiropractic of Merrimack and Wellness Center**? _____

Has your child ever benefited from chiropractic care? Yes No

When was their last visit? _____

Reason for today's Chiropractic evaluation: _____

Have you consulted any other health care practitioners for this reason? _____

If Yes, Who? _____

What are your goals for your child in this office? _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature _____ Date _____

Health History

Many of the health challenges that people will face originate from stressors experienced during developmental years (including gestation and birth). These stressors (traumas) may be emotional, physical, or chemical. **This health record is designed to help us understand the stressors your child might have already experienced, and to maximize your child's health and wellness.**

The Pregnancy Process

During the pregnancy process, did the mom:

- Take medications? Type _____
- Smoke or consume alcohol or drugs? _____
- Experience any illness? Type _____
- Undergo a lot of stress? _____
- Receive other radiation? _____ How many? _____

The Birthing Process

Birthplace: Home Hospital Birthing Center

Type of Birth: Vaginal C-Section Cephalic (head first) Breech (feet first) Occiput Posterior (facing forward)

Procedures: Forceps Vacuum Extraction

Birth Assistants: M.D. Midwife Doula

Did the person assisting the delivery twist or pull the baby during the delivery? Yes No

How long did labor & delivery last? _____ hours

What was the mother's position during labor? Back Side

Sitting Standing Other _____

Did the mother have an episiotomy? Yes No

Was labor chemically induced? Yes No

What was the child's gestational age at birth? _____

Were any drugs administered during the labor process (IV, epidural)?

Yes No

Was your child subjected to any of the following? Silver Nitrate eye drops

Incubation (how long?) _____ Vitamin K injection

Hepatitis injection Separation from mother (how long?) _____

Vaccinations

Have you chosen to vaccinate your child? Yes No

If yes, check all vaccinations received: DPT MMR Polio

Chicken Pox Hepatitis Flu Other _____

Describe any reactions to the vaccine(s): _____

Growth and Development

At what age did your child?

Follow an object _____ Respond to sound _____
Hold up head _____ Vocalize _____
Sit unassisted _____ Teethe _____
Crawl _____ Walk _____

vision problems pink eye constipation
 headaches ear problems asthma
 sleeping difficulty tubes in the ears colic
 irritability attention problems hyperactivity
 skin problems frequent colds bedwetting
 breathing problems digestive problems allergies (list) _____

other _____

Notes: _____

Is your child accident-prone? _____

Average number of hours your child watches television, plays on the computer, or plays electronic games each week, if any? _____

Do you feel that your child's social and emotional development is normal for their age? (Please explain) _____

Does your child have any night terrors, sleep walking, difficulty sleeping? No Yes

If yes please explain: _____

Has your child:

Been hospitalized/surgery? No Yes: _____

Had a severe fall? No Yes: _____

Been in a car accident? No Yes: _____

Has your child had traumas resulting in bruises, fractures, or stitches? _____

Any sports participation? (Please list)

Approximate hours of playtime each week _____

Is a school backpack used? (Heavy or Light) _____

Has your child ever taken antibiotics? Yes No

If yes, how often & why? _____

Has your child ever taken or currently taking any other medications (OTC or prescription)?

Yes No If yes, explain: _____

Was your child breast fed? Yes No

If yes, for how long? _____

Does your child consume?

fruits vegetables lean meats and fish

nuts omega 3 fatty acid supplement Probiotics

caffeine soda sugar artificial sweetener fast food

processed foods water