FAMILY CHIROPRACTIC OF MERRIMACK & WELLNESS CENTER

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

The Birthing Process

Birthplace: **O** Home **O** Hospital **O** Birthing Center
Type of Birth: **O** Vaginal **O** C-Section **O** Cephalic (head first) **O** Breech (feet first) **O** Occiput Posterior (facing forward)
Procedures: **O** Forceps **O** Vacuum Extraction
Birth Assistants: **O** M.D. **O** **M**idwife **O** Doula
Did the person assisting the delivery twist or pull the baby during the delivery? **O**Yes **O**No
How long did labor & delivery last? _____ hours
What was the mother's position during labor? **O** Back **O** Side
O Sitting **O** Standing **O** Other_____
Did the mother have an episiotomy? **O** Yes **O** No
Was labor chemically induced? **O** Yes **O** No
What was the child's gestational age at birth? _____
Were any drugs administered during the labor process (IV, epidural)?
O Yes **O** No
Was your child subjected to any of the following? **O** Silver Nitrate eye drops
O Incubation (how long?) _____ **O** Vitamin K injection
O Hepatitis injection **O** Separation from mother (how long?) _____

Vaccinations

Have you chosen to vaccinate your child? **O** Yes **O** No
If yes, check all vaccinations received: **O** DPT **O** MMR **O** Polio
O Chicken Pox **O** Hepatitis **O** Flu **O** 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_____

O vision problems **O** pink eye **O** constipation
O headaches **O** ear problems **O** asthma
O sleeping difficulty **O** tubes in the ears **O** colic
O irritability **O** attention problems **O** hyperactivity
O skin problems **O** frequent colds **O** bedwetting
O breathing problems **O** digestive problems **O** allergies (list) _____
_____
O 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? **O** No **O** Yes
If yes please explain: _____
Has your child:
Been hospitalized/surgery? **O** No **O** Yes: _____
Had a severe fall? **O** No **O** Yes: _____
Been in a car accident? **O** No **O** 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? **O** Yes **O** No
If yes, how often & why?_____
Has your child ever taken or currently taking any other medications (OTC or prescription)?
O Yes **O** No If yes, explain: _____

_____

Was your child breast fed? **O** Yes **O** No

If yes, for how long?_____

Does your child consume?

O fruits **O** vegetables **O** lean meats and fish

O nuts **O** omega 3 fatty acid supplement **O** Probiotics

O caffeine **O** soda **O** sugar **O** artificial sweetener **O** fast food

O processed foods **O** water