THE BALANCED ATLAS
EST. 2013
SAN FRANCISCO

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Confidential Child Information

Date _____

Child's Name _____

Parent(s) Names

_____

Siblings' Names and Ages

_____

Address _____ City/Town _____ Postal Code _____

Parents' E-mail Address

_____

Date of Birth _____m/_____d/_____y/ Gender: ◯ Male ◯ Female

Home and/or Cell Ph _____ Business Ph _____

Best number to contact you? _____

Who/What may we thank for referring your child to this office? _____

Circle the phrase that most represents your child's reason for care:

◯ Wellness ◯ Prevention ◯ Feel good ◯ Symptom Relief

Reason for your child seeking services at our office: _____

Has your child ever seen a Chiropractor? If yes, who? Date of last visit: _____

Name & Address of Obstetrician/ Midwife:

_____

Name & Address of Primary Health Care Provider:

_____

Date of last visit _____ Purpose of visit _____

Health Concerns

Please list your child's heath concerns according to their severity:

Concern	Rate of Severity 1=mild, 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	% of time is pain present?
1.					
2.					
3.					
4.					

Pregnancy and Birth History

Gestational Duration: _____ weeks

PHYSICAL STRESS

Trauma/Falls during pregnancy_____

Invasive Procedures (Eg. Amniocentesis, CVS) ? ◯ Yes ◯ No

CHEMICAL STRESS

During the pregnancy did the mother:

Smoke? ◯ Yes ◯ No How much? _____

Drink Alcohol? ◯ Yes ◯ No How much? _____

Prescription Medications? ◯ Yes ◯ No How much? _____

Recreational Drugs? ◯ Yes ◯ No How much? _____

Fall ill during pregnancy? ◯ Yes ◯ No please explain _____

Were any supplements taken during the pregnancy? ◯ Yes ◯ No

Please list: _____

EMOTIONAL STRESS

Please rate your stress levels during pregnancy 1-10 (1= low, 10=high):_____

LABOR

Was labor induced? ◯ Yes ◯ No

Duration of labor? _____

Duration of active (pushing stage) labor?_____

Did mother receive medications? ◯ Yes ◯ No

If yes, which: _____

BIRTH

Type of birth? ◯ Vaginal: Cephalic (head first) ◯ Breech (feet first) ◯ C-Section

Location of birth? ◯ Home ◯ Hospital ◯ Birthing center

Birth Assistants? ◯ Midwife ◯ Doula ◯ Obstetrician

Was there any assistance needed during birth?

◯ Forceps ◯ Cesarean ◯ Vacuum Extraction ◯ Induction ◯ Assisted Traction/Head Turning

Was delivery considered normal? ◯ Yes ◯ No

Were there complications during birth? ◯ Yes ◯ No

Please explain:

_____

Was there any evidence of birth trauma to the infant? Check all that apply:

◯ Bruising ◯ Odd shaped head

◯ Stuck in birth canal ◯ Fast or excessively long birth

◯ Respiratory depression ◯ Cord around neck

Was your child subjected to any of the following? Check all that apply:

◯ Silver nitrate drops in eyes ◯ Incubation How long? _____

◯ Vitamin K shot ◯ Separation from you How long? _____

◯ Hepatitis shot

Did your child spend any time in intensive care? Yes No If yes, how long? _____

APGAR score at birth? _____ APGAR score at 5 minutes? _____

Birth Weight? _____ Birth Length? _____

Childhood History

PHYSICAL STRESS

Does your child have a preferred sleeping position? ◯ Yes ◯ No _____

Did your child prefer one-sided breast-feeding position? ◯ Yes ◯ No _____

Did your baby spit up after feeding? ◯ Yes ◯ No _____

Any falls or injuries down stairs, bicycle etc? ◯ Yes ◯ No _____

Does child ever bang his/her head repeatedly? ◯ Yes ◯ No _____

Any traumas resulting in bruises, fractures, stitches? ◯ Yes ◯ No _____

Any hospitalizations or surgeries? ◯ Yes ◯ No _____

Please list all surgeries your child has had:

1. Type _____ When _____ Doctor _____

2. Type _____ When _____ Doctor _____

Please list any accidents and/or injuries: auto, sports, or other (Especially those related to your child's present problems).

1. Type_____ When_____ Hospitalized? ◯ Yes ◯ No

2. Type_____ When_____ Hospitalized? ◯ Yes ◯ No

3. Type_____ When_____ Hospitalized? ◯ Yes ◯ No

Have you ever had x-rays taken? ◯ Yes ◯ No When?_____ Where?_____

What area of your child's body:_____

Does your child play sports? ◯ Yes ◯ No _____

If yes, hours per week? _____ Age child began? _____

Is school backpack used? ◯ Yes ◯ No Weight of backpack? _____lbs

Approximate hours spent at play per week? _____

Average time spent at computer/TV/video games per week? _____ hrs

Does your child wear glasses or contact lenses? ◯ Yes ◯ No _____

Does your child have trouble reading the board? ◯ Yes ◯ No _____

Does your child have difficulty with coordination? ◯ Yes ◯ No _____

CHEMICAL STRESS

Was/is child breast-fed? ◯ Yes ◯ No For how long?

_____

At what age was:

Formula introduced? _____ Brand? _____

Cow's milk introduced? _____

Solid food? _____

Food/juice intolerance? ◯ Yes ◯ No_____

Does your child have food allergies? ◯ Yes ◯ No_____

Please circle any dietary selection that is appropriate for your child, and grade according to the following scale:

Daily:
D - Consume this daily
FD - Consume this a few times per day

Monthly:
M - Consume this monthly
FM - Consume a few times per month

Weekly:
W - Consume this weekly
FW - Consume this a few times per week

Never:
O - Do not consume this

Eggs	_____	Fasting	_____	Fruit	_____		
Fish	_____	Diet Food	_____	Organic Foods	_____		
Coffee	_____	Beef	_____	Weight Control Diet	_____	Raw Vegetables	_____
Soft Drink	_____	Poultry	_____	Artificial Sweetener	_____	Whole Grains	_____
Fried Foods	_____	Seafood	_____	Cooked vegetables	_____		
Refined Sugar	_____	Dairy	_____	Canned/Frozen vegetable	_____		

Does your child have a bowel movement every day? ◯ Yes ◯ No _____

Does your child have regular or occasional skin rashes? ◯ Yes ◯ No _____

What vaccinations were given and at what age?

_____

_____

Reason for vaccinations _____

Were there any negative reactions? ◯ Yes ◯ No _____

Was there any:

◯ Fever ◯ Un-consolable crying

◯ Irritability ◯ Arching of body

◯ Bowel disturbances ◯ Feeding disturbances

◯ Drowsiness ◯ Other: _____

History of antibiotics? ◯ Yes ◯ No

If so, how many coursed of antibiotics has your child received in their lifetime? _____

Reason and length of last course of antibiotics? _____

Please list ALL medications your child currently takes or has taken in the past 6 months:

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Name _____ Dosage _____ For what? _____

Please list all nutritional supplements, vitamins, homeopathic remedies your child presently takes:

Name _____ For what? _____

Name _____ For what? _____

Are there pets in the home? ◯ Yes ◯ No _____

Are there any smokers at home? ◯ Yes ◯ No _____

EMOTIONAL STRESS

Did mother have any difficulties with breast-feeding?

Did mother and baby have difficulty bonding?

Did mother experience any post-partum depression?

Night terrors, sleep walking, difficulty sleeping ◯ Yes ◯ No _____

Do you consider their sleeping pattern normal? ◯ Yes ◯ No _____

Quality of Sleep? ◯ Good ◯ Fair ◯ Poor Number of hours _____

Behavior problems? ◯ Yes ◯ No

_____

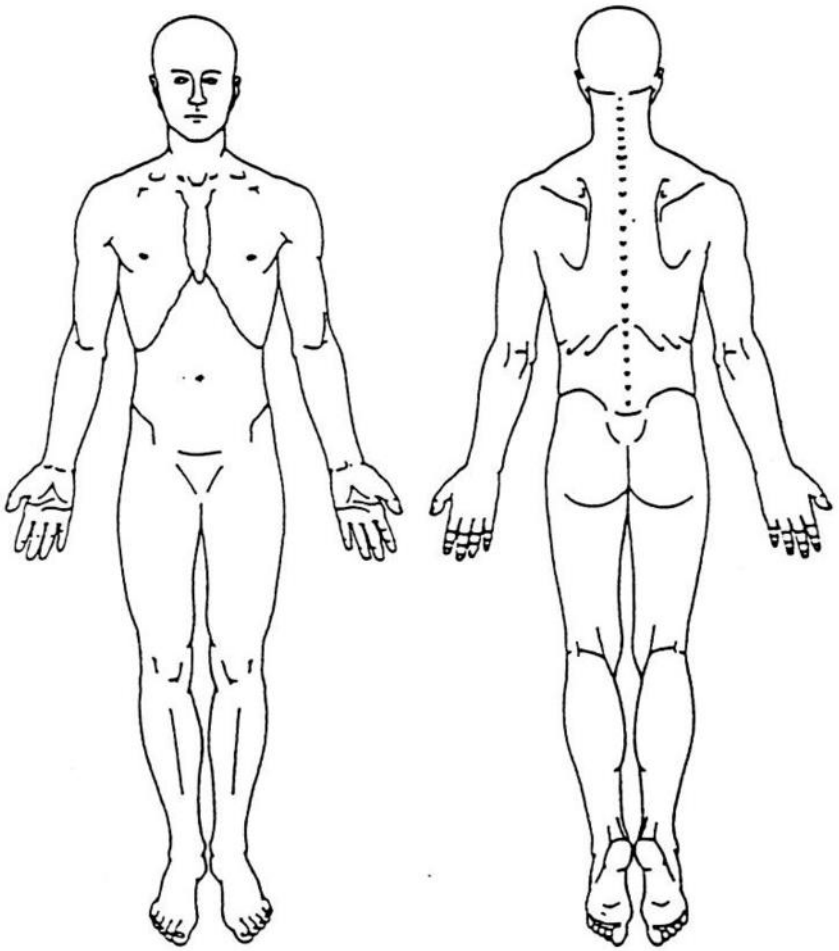
Do you feel that your child's social and emotional development is normal for their age? ◯ Yes ◯ No

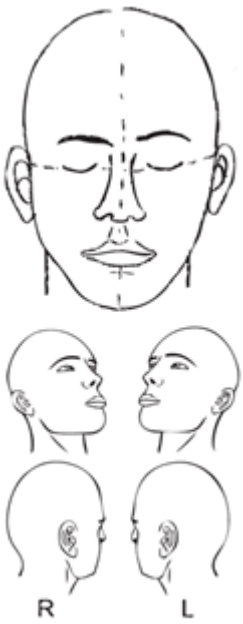
Does your child attend day care? ◯ Yes ◯ No From what age? _____

Symptomatic Diagram

Using the letters below, mark the areas on your body where you feel the descriped sensations.

A=Ache B=Burning N=Numbness P=Pins & Needles S=Stabbing





Is there anything else which may help to better understand your child's health which has not been discussed?

_____
_____
_____
_____

Print Guardian Name: _____ Date: _____

Guardian Signature: _____