CHILD HEALTH PROFILE & PERMISSIONS - Completed by Parent

Initial Visit Date: ______/______/______

Name of Parent: ______________________________ **Name of Child:** ______________________________

Address: ____

City/State/Zip: ____

Work Phone#: _________________________________ Home Phone#: ____________________________

Date of Child's Birth: _____/_____/_____ Child's Age: ______ Child's Gender: Male Female

How did you hear about our office? ____

Has your child ever received Spinal Adjustments or Network Spinal Analysis Entrainments by a Doctor of Chiropractic before? YES NO

If yes when and by whom? _____________________________ How long did your child go? __________

Have you or your spouse ever received Chiropractic care? YES NO Network Care? YES NO

What other natural forms of healthcare has your child received? ________________________________

What do you hope for your child to receive from Chiropractic care in this office? ___________

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PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR CHILD'S HEALTH HISTORY

Were you physically ill prior to or during the pregnancy? YES NO ______________________________

Was the pregnancy difficult? YES NO ____

Did you have any falls, accidents or physical injuries during the pregnancy? YES NO

Was your labor chemically induced? YES NO ____

Were you conscious / semiconscious / unconscious? ____

Was the birth: _drug induced _forceps or suction _C-section _breech

_natural _prolonged _cord around the neck

Was the birth: _at home _in a birthing center _in a hospital _other ______________________

Was your child incubated or isolated? YES NO ____

Was your child: _bottle fed _breast fed _other ____

Has your child experienced any of the following? (If so please list when and any further comments you wish to share):

_Headaches _Allergies _Ear infections _Breathing problems _Fatigue _Irritability

_Hyperactivity _Flu _Frequent colds _Bloody noses _Meningitis _Diarrhea _Colic

_Constipation _Rashes _Milk or lactose intolerance _Bed Wetting _Asthma

_Sleeping disorders _Digestive problems _Other ____

Regarding your child today:

Has your child ever been unconscious? YES NO ____

Has your child ever used crutches or corrective braces? YES NO ______________________________

Is your child accident-prone? YES NO ____

Has your child had any falls down steps? YES NO ____

Has your child ever been involved in an auto accident? YES NO ______________________________

Has your child ever been hospitalized or had surgery? YES NO _______________________________

Has your child ever had any broken bones or sprain injuries? YES NO ________________________

Is your child currently on any medications? YES NO In the past? YES NO

Please List Medications ____

Has your child been vaccinated? YES NO ____

Is your child active in any particular sports? YES NO If yes which ones? ______________________

Is your child hyperactive? YES NO ____

Does your child have learning disorders? YES NO ____

Does your child have poor posture? YES NO ____

Is your child nervous, or has anyone suggested that your child was nervous? YES NO __________

How would you rate your child's physical health?
_excellent _good _fair _poor _getting better _getting worse

How would you rate your child's emotional/mental health?
_excellent _good _fair _poor _getting better _getting worse

Is there anything else you wish to share which may help us to better understand your child?

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I hereby authorize Dr. Jasmine Therese Esguerra, DC, of Pure Wellness International, and whomever she may designate, to administer care necessary to my child named above.

Parent/Guardian's Name: ________________________________

Parent/Guardian's Signature: ______________________________ Witness: __________________________

Dated this ________ day of _________________ 200_____