PARENT/CHILD COMPREHENSIVE HEALTH PROFILE

Name of Parent: ________________________ Name of Child: _____________________

Address: ____

City/State/Zip: ____

Phone# Work: ____________________ Home: __________________Cell:______________

Email: ____________________ Child's Date of Birth: ____/____/____ Age: _____ Sex: M F

How did you hear about our office? ____

Has your child ever received spinal adjustments by a Chiropractor before? Y N

If yes when and by whom? _____________________ How long did your child go?___

Have you or your spouse ever received chiropractic care? Y N

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?____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR CHILD'S HISTORY

Were you physically ill prior to or during the pregnancy? Y N

Was the pregnancy difficult? Y N

Did you have any falls. accidents or physical injuries during the pregnancy? Y N

Was your labor chemically induced? Y N

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? Y N
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? Y N

Has your child ever used crutches or corrective braces? Y N

Is your child accident-prone? Y N

Has your child had any falls down steps? Y N

Has your child ever been involved in an auto accident? Y N

Has your child ever been hospitalized or had surgery? Y N

Has your child ever had any broken bones or sprain injuries? Y N

Is your child on any medications? Y N

Has your child been vaccinated? Y N

Is your child active in any particular sports? If yes which ones ________________

Is your child hyperactive? Y N

Does your child have learning disorders? Y N

Does your child have poor posture? Y N

Is your child nervous, or has anyone suggested that your child was nervous? Y N

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 may wish to share which may help us to better

understand your child?____

I hereby authorize Dr. Anne Jenkins, D.C. and whomever she may designate to

administer care as she deems necessary to my son/daughter.

Signed: __________________________________ Date: _____________