Inspire Me Chiropractic Studio & Health Spa
Phone: 678.819.2556 1503 Johnson Ferry Rd, Ste 100
www.inspiremenaturally.com Marietta, GA 30062

Pediatric/Youth Comprehensive Health Profile / History

*Please do your best to fill out *everything* on this intake form. It is important that we understand past and current stressors that may have affected and could possibly continue to affect your child physically, emotionally, mentally, chemically, and spiritually. It is important for us to know the following information, even if it may not seem relevant to the reason for which you came in for care. Please know that we value your time and only aim to provide you the best care possible. Thank you for choosing Inspire Me!

Please check the type of care desired:
___ Temporary Relief ___ Stabilization ___ Family Health/ Prevention ___Doctor's Advice

Participant Name: _____ **Sex**: Male / Female
First Middle Last
Address: _____
Street City State Zip Code
Home Phone: _____ **Cell Phone**: _____
(Please star the best number to reach you.)
Date of Birth: ___/___/___ Age: ____ Weight: _____ Height: _____

E-Mail: _____ Sibling(s): Name(s) and Age(s): _____
_____

Parents/Emergency contact Names: _____
Alternate Phone Numbers: _____

Purpose for contacting us? _____
_____
Other doctors seen for this: Y N Who? _____
Other health concerns: _____

How did you discover our office, and the professional services we offer? _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, stairs). Was this the case with your child? Y N

About Your Health

The human body is designed to be healthy. Throughout life, events occur and our body has two choices: It can either integrate the physical, mental, chemical, emotional or spiritual stress or it can store that experience to be integrated at a later time when the body is willing, ready, and able. These stored experiences eventually become symptoms in the body thus giving us a lesser quality of life than we deserve. This case history will uncover the layers of stored experiences in your body, particularly in the nervous system. Following the Chiropractic Exam, you will get an outline of care that will begin to correct these layers and recover your innate health potential!

About Your Care

Chiropractic provides different levels of care. The first is Initial Intensive care which corrects the most recent layers of stored patterns of tension. This care usually reduces or eliminates symptoms. Then begins Reconstructive Care which corrects the years of stored patterns of tension that have gotten you where you are now. This is when stabilization is being achieved in the body. Next comes Wellness/Continual Progression Care. The body is designed to excel - mind, body and soul. That is the goal at this level of care. All of these options will be explained at your Doctor's Report. You can then decide which level of care fits your goals in health and life!

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Developmental History (Birth to Age 5)

Yes	No	(Pre-natal - Birth)	Participant's Comments	Doctor's Comments
1. ***Pregnancy:*** ***(Answer regarding the birth mother)***				
☐	☐	Smoke/drink alcohol/medications? (circle)	_____	_____
☐	☐	Have a healthy/proper diet?	_____	_____
☐	☐	Exercise throughout pregnancy?	_____	_____
☐	☐	Falls/injuries during pregnancy?	_____	_____
☐	☐	Experience any physical/mental abuse?	_____	_____
☐	☐	Receive ultrasounds? How many?	_____	_____
☐	Obstetrician ☐ Midwife	☐ Nurse Midwife?	_____	_____
2. ***Birth Process***				
☐	☐	Was the delivery long/difficult? (circle)	_____	_____
☐	☐	Was it a positive birthing/delivery process?	_____	_____
☐	☐	Was it what you planned?	_____	_____
☐	☐	Vacuum extraction? Forceps?	_____	_____
☐	☐	Caesarean? Emergency or Scheduled?	_____	_____
☐	☐	Positioning other than cephalic?	_____	_____
☐	Home Birth ☐ Birthing Center	☐ Hospital Birth	_____	_____
☐	☐	Mother given drugs during labor/delivery?	_____	_____
☐	☐	Was labor induced? Pitocin? Epidural?	_____	_____
☐	☐	Water birth?	_____	_____
☐	☐	Positioned on her back?	_____	_____

Yes	No	(Birth – Age 5)	Participant Comment	Doctor's Comment
		3. Growth & Development		
☐	☐	Breast fed? How long?	_____	_____
☐	☐	Formula fed? How long? Dairy or soy?	_____	_____
☐	☐	Introduced solids at what age?	_____	_____
☐	☐	Introduced cow's milk at what age?	_____	_____
☐	☐	Illnesses/allergies?	_____	_____
☐	☐	Vaccinations? Which ones?	_____	_____
☐	☐	Accidents?	_____	_____
☐	☐	Surgery?	_____	_____
☐	☐	Drugs/Medications?	_____	_____
☐	☐	Were they picked on by siblings/family?	_____	_____
	☐	Physical, emotional, or sexual abuse?	_____	_____
☐	☐	Spanking? Frequency and with what?	_____	_____
☐	☐	Chair pulled out while seated?	_____	_____

☐	☐	Sleeping issues, nightmares/terrors?	_____	_____
☐	☐	Fell down stairs? (Even minor?)	_____	_____
☐	☐	Play in a bouncy swing?	_____	_____
☐	☐	Crawled before walking?	_____	_____
☐	☐	Were they pulled by their arm?	_____	_____
☐	☐	Other traumas? What? When?	_____	_____
☐	☐	Special diet?	_____	_____

Yes	**No**	**(Age 5 - present)**	**Participant Information** (if answer is Yes)	**Doctor's Comment**
☐	☐	Were they taught proper body movement and care? (Spinal hygiene?)	_____	_____
☐	☐	Diet (Do they eat healthy foods?)	_____	_____
☐	☐	Have they been in <u>any</u> accidents?	_____	_____
☐	☐	Illnesses/allergies?	_____	_____
☐	☐	Vaccinations? Which ones?	_____	_____
☐	☐	Surgery and/or organs removed/replaced?	_____	_____
☐	☐	Teeth issues?	_____	_____
☐	☐	Eye issues?	_____	_____
☐	☐	Hearing issues?	_____	_____
☐	☐	Exercise regularly? What type?	_____	_____
Sleeping habits: hours per night? ____		Quality?	_____	_____
☐	☐	Nightmares? special pillow?	_____	_____
☐	☐	Physical stress?	_____	_____
☐	☐	Mental/emotional stress?	_____	_____
☐	☐	Hobbies/Sports injuries?	_____	_____
☐	☐	Physical, emotional, sexual abuse?	_____	_____
☐	☐	Other traumas/problems?	_____	_____

<u>Internal Intake:</u>	**<u>Daily/High</u>**	**<u>Weekly/Moderate</u>**	**<u>Monthly or less/Low</u>**	**<u>None/Never</u>**
Dairy	_____	_____	_____	_____
Meat	_____	_____	_____	_____
Vegetables	_____	_____	_____	_____
Fruit	_____	_____	_____	_____
Soy	_____	_____	_____	_____
Sugar	_____	_____	_____	_____

Soda/Energy Drinks	_____	_____	_____	_____
Fast food	_____	_____	_____	_____
Candy	_____	_____	_____	_____
Water	_____	_____	_____	_____

What kind of water does your family drink? _____
Do you eat organic foods? Yes No _____
Do you use organic health products (soaps, shampoos, detergents, etc.)? Yes No _____
Do you feel you have good quality of air at home? Yes No _____

Mark each they have had in the past or have now. Put "P" for past and "N" for now.

___ Ear Infections ___ Frequent infections ___ Respiratory disorder/disease
___ Sinus problems ___ Allergies ___ Asthma ___ Cold hands/feet
___ Nervous disorder ___ Digestive problems ___ Headaches (_____x/_____)
___ Changes in bowel/bladder ___ Concussion /Head injury ___ Neurological issues
___ Decrease Range of Motion ___ Acid Reflux /Frequent Gas ___ Colic or Excessive Moodiness
___ Motor Integration Issues ___ Sensory Integration Issues ___ Learning Issues/Disabilities
___ Other: _____

□ Chicken Pox: age _____ □ Rubella: age _____
□ Mumps: age _____ □ Rubeola: age _____
□ Whooping Cough: age _____ □ Other: _____ age _____

Number of doses of antibiotics you have given your child:
During the past six months: _____ During his/her lifetime: _____ Number of doses of other prescription medications you have given your child: During the past six months: _____ During his/her lifetime: _____
Number of doses of over the counter medications you have given your child:
During the past six months: _____ During his/her lifetime: _____

Previous Chiropractic Care

Does your family currently receive chiropractic care? Y N
If no, have they in the past? Y N
Has your child ever been adjusted? Y N Who? _____
When? _____ Duration of care: _____
Reason for visit: _____ Are they still going? Y N
Result: _____ Technique used: _____

Has your child been involved in any of the following?

___ Soccer ___ Football ___ Gymnastics ___ Baseball ___ Basketball ___ Cheerleading
___ Martial Arts ___ Ballet ___ Dance/ Tap ___ Hockey (___ice ___field) ___ Tennis
___ Swimming ___ Biking ___ Track/ Running ___ Lacrosse ___ Marching Band/ Colorguard
___ Golf ___ Wrestling ___ Volleyball Other: _____

Has your child ever been seen on an emergency basis? Y N Why? _____

Females: Menarche (1st menstrual cycle) Y N If yes, Age: _____

We are here to serve you, and encourage you to ask questions. Your participation is vital and will help determine your results. Remember, positive thinking is as important as your actions. A thistle seed can only produce a thistle, and a sunflower seed will only create a sunflower!

I hereby authorize Inspire Me and its Doctors to administer chiropractic services to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parent/ Guardian Name: _____ Signature: _____ Date: _____